STAR Kids Handbook

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Glossary

Effective November 1, 2016

Agency Option (AO) — A service delivery option under which the provider is responsible for managing the day-to-day activities of the attendant and all business details.

CCP — Comprehensive Care Program, a package of Medicaid services available to clients based on medical necessity that goes beyond regular Medicaid services for all ages and is part of the Texas Health Steps benefit for clients under the age of 21.

CFR — Code of Federal Regulations, the codified federal regulatory law that governs most federal programs, including Medicaid.

CLASS — Community Living Assistance and Support Services, a non-capitated 1915(c) waiver for individuals with intellectual or developmental disabilities.

CMS — Centers for Medicare and Medicaid Services, the federal agency that administers Medicare and Medicaid.

Community First Choice (CFC) — CFC enables Texas Medicaid to provide the most cost effective approach to basic attendant and habilitation service delivery so members can remain in the community. The services available in CFC are personal assistance services, habilitation services, emergency response services and support management

Consumer Directed Services (CDS) — A service delivery option in which a member or legally authorized representative employs and retains service providers and directs the delivery of Personal Care Services (PCS), Community First Choice (CFC) PAS/HAB, and MDCP services including respite services, employment assistance, supported employment, Financial Management Services, and flexible family support services A member participating in the CDS option is required to use a CDS agency chosen by the member or legally authorized representative (LAR) to provide financial management services.

DADS — Texas Department of Aging and Disability Services

DBMD — Deaf Blind with Multiple Disabilities, a non-capitated 1915(c) waiver for individuals with intellectual or developmental disabilities.

Denial — Closure of an application with a finding of ineligibility.

Developmental Disability — As defined in the Developmental Disabilities Assistance and Bill of Rights Act of 200, Section 102(8) [42 USC 15002], a severe, chronic disability of an individual five years of age or older that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the individual attains 22 years of age; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and

reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

DSHS — Texas Department of State Health Services

EPSDT — Early and Periodic Screening, Diagnosis and Treatment, a federal Medicaid benefit for individuals under 21 years (called Texas Health Steps in Texas).

Family member — A person who is related by blood, affinity or law to an individual.

Guardian - A person appointed as a guardian of the estate or of the person by a court.

HCS — Home and Community-based Services, a non-capitated 1915(c) waiver for individuals with intellectual or developmental disabilities.

Health and Human Services Commission (HHSC) — The single state agency responsible for Medicaid.

Individual service plan (ISP) — A plan of care developed by the MCO, the member, and the member's LAR.

Intellectual and Developmental Disability (IDD) — A significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the development period.

Legally authorized representative (LAR) — A person authorized by law to act on behalf of an STAR Kids member, and may, depending on the circumstances, including a parent, guardian, managing conservator of a minor or the guardian of an adult or a representative designated pursuant to 42 C.F.R. 4315.923.

Managed Care Organization (MCO) — An insurer licensed by the Texas Department of Insurance as a Health Maintenance Organization in accordance with Chapter 843 of the Texas Insurance Code. The MCO provides Medicaid benefits to individuals who are enrolled in STAR Kids.

Member — An individual who is enrolled in and receiving services through a STAR Kids MCO.

Money Follows the Person (MFP) — A process whereby the funds used for payment of institutional care follows the person when transitioning to the community under STAR Kids.

Mutually exclusive services — Two or more services that may not be authorized for the same individual during the same time period.

Program Support Unit (PSU) — An HHSC unit of staff who support and handle certain aspects of the STAR Kids program.

Provider — An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the MCO for the delivery of covered services to the MCO's members.

PSU staff — An HHSC employee who works in PSU.

Responsible Adult--An adult, as defined by Texas Family Code §101.003, who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for a participant. Responsible adults include biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage. If the participant is 18 years of age or older, the responsible adult must be the participant's managing conservator or legal guardian

Responsible party — An individual who:

- assists and/or represents an applicant or member in the application or eligibility redetermination process; and/or
- is familiar with the applicant/member and his/her financial affairs and functional condition.

Service coordinator — The MCO staff person with primary responsibility for providing service coordination STAR Kids members.

Service Responsibility Option (SRO) — A service delivery option that empowers the member to manage most day-to-day activities. This includes supervision of the individual providing personal attendant services. The member decides how services are provided. It leaves the business details to a provider of the member's choosing.

SSA — Social Security Administration, a federal agency that authorizes Medicaid and waiver services.

SSI - Supplemental Security Income, a federal cash assistance benefit available to individuals who meet certain federal disability and income requirements. Most individuals receiving SSI who are under the age of 21 are eligible for Medicaid and are required to enroll in STAR Kids.

TAC — Texas Administrative Code, the state rules that implement programs and services.

Termination — Closure of an ongoing case due to a finding of ineligibility.

Texas Medicaid & Healthcare Partnership (TMHP) — The Texas contractor administering Medicaid provider enrollment and fee-for-service claims processing. TMHP is also responsible for processing medical necessity/level of care assessments for the MDCP waiver and CFC.

Third-Party Resource (TPR) — Any individual, entity or program that is, or may be, liable to pay for any medical assistance provided to a recipient under the approved state Medicaid plan.

THSteps — Texas Health Steps, the EPSDT benefit in Texas.

TxHmL — Texas Home Living, a non-capitated 1915(c) waiver for individuals with intellectual or developmental disabilities.

TxMedCentral — A secure Internet bulletin board the state and MCOs use to share information.

YES — Youth Empowerment Services, a non-capitated 1915(c) waiver for individuals with severe emotional disturbance.

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1000 Overview and Eligibility

Senate Bill 7 from the 83rd Legislature, Regular Session, 2013 required the Texas Health and Human Services Commission (HHSC) to create the State of Texas Access Reform (STAR) Kids program. STAR Kids is a Medicaid managed care program for children with disabilities in Texas, which integrates acute care and long term services and supports (LTSS) delivered by a managed care organization.

STAR Kids does not change or impact an individual's Medicaid eligibility, nor does STAR Kids impact access to Medicaid services and supports. STAR Kids does change the way in which services are delivered. Children and young adults, ages birth through 20, enrolled in a STAR Kids managed care organization (MCO) are called members of the MCO. All STAR Kids members have access to service coordination, provided by an MCO employee or through a member's primary care provider, authorized by the MCO.

Service coordination is specialized care management performed by a service coordinator and includes but is not limited to:

- identification of needs, including physical health, behavioral health services, and LTSS development of an individual service plan (ISP) to address those identified needs;
- assistance to ensure timely and a coordinated access to an array of providers and services;
- attention to addressing unique needs of members; and
- coordination of Medicaid benefits with non-Medicaid services and supports, as necessary and appropriate.

All STAR Kids members receive a comprehensive assessment of their physical and functional needs by a service coordinator using the STAR Kids Screening and Assessment Instrument (SK-SAI), annually. If a member has a change in their physical or behavioral health or a change in functional ability or caregiver supports, the MCO must reassess the member upon request from the member, their legally authorized representative, or health home, update their individual service plan, as applicable, and authorize necessary services.

In addition to traditional Medicaid services, STAR Kids MCOs are responsible for delivering additional services to children enrolled in the Medically Dependent Children Program (MDCP). MDCP provides respite, flexible family support services, adaptive aids, minor home modifications, employment services, and transition assistance to children and young adults who meet the level of care provided in a nursing facility so they can safely live in the community. The State appropriates the program a limited number of slots, so HHSC maintains an interest list for MDCP. A child, young adult, or their legally authorized representative (LAR) may ask their MCO about how to be placed on the MDCP interest list at any time.

1100 Legal Basis and Values

STAR Kids Medicaid Managed Care Program is required by Texas Government Code, §533.00253. The Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapters M - Home and Community Based Services in Managed Care and N -STAR Kids outline the delivery of Medically Dependent Children Program services as well as the STAR Kids program. Requirements pertaining to managed care organizations (MCOs) are outlined in the STAR Kids Managed Care Contract and in this Handbook.

The STAR Kids Handbook includes policies and procedures to be used by all health and human services agencies and their contractors and providers in the delivery of STAR Kids Program services to eligible members. The STAR Kids Handbook can be found on the Texas Health and Human Services Commission (HHSC) website.

1110 Mission Statement

Texas Health and Human Services Commission's (HHSC) mission is to provide individually appropriate Medicaid managed care services to children and young adults with disabilities to enable them to live and thrive in a setting that maximizes their health, safety, and overall well-being. To achieve HHSC's mission, the STAR Kids program is established to:

1. Coordinate care across service arrays;
2. Improve quality, continuity, and customization of care;
3. Improve access to care and provide person-centered health homes;
4. Improve ease of program participation for members, MCOs, and providers;
5. Improve provider collaboration and integration of different services;
6. Improve member outcomes to the greatest extent achievable;
7. Prepare young adults for the transition to adulthood;
8. Foster program innovation; and
9. Achieve cost efficiency and cost containment.

1200 STAR Kids Services and Service Delivery Options

STAR Kids members are entitled to all medically and functionally necessary services available in the same amount, duration, and scope as in traditional fee-for-service Medicaid, described in the Texas Medicaid state plan and the Texas Medicaid Provider Procedure Manual (TMPPM) through their selected managed care organization.

1210 Acute Care Services

STAR Kids members may receive any medically necessary services through their managed care organization (MCO), and as required under the Early and Periodic Screening, Diagnostics and Treatment (EPSDT), (42 CFR Part 441). This includes, but is not limited to:

- ambulance services;
- audiology services, including hearing aids;
- behavioral health services, including:

    - in-patient mental health services;
    - out-patient mental health services;
    - out-patient chemical dependency services for children;
    - detoxification services; and
    - psychiatry services;
- birthing services provided by a certified nurse midwife in a birthing center;
- chiropractic services;
- dialysis;
- durable medical equipment and supplies;
- emergency services;
- family planning services;
- home health care services;
- hospital services, inpatient;
- hospital services, out-patient;
- laboratory;
- medical checkups and Comprehensive Care Program (CCP) services for children and young adults through the Texas Health Steps Program;
- oral evaluation and fluoride varnish in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age;
- optometry, glasses and contact lenses, if medically necessary;
- podiatry;
- prenatal care;
- primary care services;
- radiology, imaging and X-rays;
- specialty physician services;
- therapies, including physical, occupational and speech;
- transplantation of organs and tissues; and
- vision.

STAR Kids members who have other insurance, like Medicare or private insurance, will receive most of their acute care services through their primary insurance. Members receive dental care through their primary insurer, through their selected Medicaid dental maintenance organization (DMO), or through a Medicaid fee-for-service model.

1220 Long Term Services and Supports

STAR Kids members who have an assessed need for long term services and supports (LTSS), identified by the STAR Kids Screening and Assessment Instrument, may receive the following services through their STAR Kids managed care organization (MCO):

- Day Activity Health Services (DAHS) for members 18 through 20. DAHS includes nursing and personal care services, therapy extension services, nutrition services, transportation services and other supportive services.
- Personal care services (PCS), which provide assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision or cueing, including nurse-delegated tasks.
- Prescribed pediatric extended care center (PPECC), which is a facility that provides nonresidential basic services, including medical, nursing, psychosocial, therapeutic, and

developmental services, to medically dependent or technologically dependent individuals under the age of 21 up to 12 hours/day.
- Private duty nursing (PDN) are nursing services for members who meet medical necessity criteria outlined in the SK-SAI and who require individualized, continuous, skilled care beyond the level of skilled nursing visits provided under Texas Medicaid home health services.

STAR Kids members who have an assessed need for long term services and supports (LTSS), identified by the STAR Kids Screening and Assessment Instrument, and who meet an institutional level of care may receive the following service through their STAR Kids MCO:

Community First Choice (CFC), which is available to all STAR Kids members who meet an institutional level of care for a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability or related condition, or an institution for mental disease. Members enrolled in a waiver program for individuals with an intellectual disability or related condition receive CFC through their waiver provider. CFC services include:

- Personal Assistance Services (also called CFC-PAS or CFC-personal care services), which provide assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision or cueing, including nurse-delegated tasks.

Note: CFC-PAS is the same service as PCS. The key difference is that CFC-PAS is part of the CFC benefit and must be reported differently. Members may choose to receive CFC PAS only if they do not need or want CFC habilitation.

- Habilitation, (also called CFC habilitation, or CFC-HAB), which provides acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
- Emergency Response Services (ERS), which are back-up systems and supports, including electronic devices with a backup support plan to ensure continuity of services and supports.
- Support Management, which is training provided to members and/or the members' legally authorized representative (LAR) on how to manage and dismiss their attendants.

STAR Kids members enrolled in the Medically Dependent Children Program (MDCP) are eligible for additional services through their MCO as a cost-effective alternative to living in a nursing facility. Receipt of MDCP services does not impact a member's eligibility for other LTSS available in STAR Kids. Additional services available to STAR Kids members in MDCP are:

- Adaptive aids, which are needed to treat, rehabilitate, prevent or compensate for a condition that results in a disability or a loss of function and helps a member perform the activities of daily living or control the environment in which they live. Adaptive aids must only be authorized after exhausting all Medicaid state plan services and other third-party resources.
- Employment assistance, which is assistance provided to a member to help the member locate paid, competitive employment in the community.
- Financial management services (FMS) for members who choose the consumer directed services option. FMS provides assistance to members with managing funds associated with the services elected for self-direction. The service includes initial orientation and

ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

- Flexible family support services are direct care services needed because of a member's disability that help a member participate in child care; post-secondary education; employment; independent living; or support a member's move to an independent living situation.
- Minor home modifications are physical changes to a member's residence that are needed to prevent institutionalization or to support the most integrated setting for a member to remain in the community.
- Respite services are direct care services needed because of a member's disability that provides a primary caregiver temporary relief from care giving activities when the primary caregiver would usually perform such activities.
- Supported employment provides assistance to sustain paid, competitive employment to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which members without disabilities are employed.
- Transition assistance services are a one-time service provided to a Medicaid-eligible resident of a nursing facility located in Texas to assist the resident in moving from the nursing facility into the community to receive MDCP services.

1230 Service Delivery Options for Certain Long Term Services and Supports

STAR Kids provides members with an array of services, as identified on the individual service plan (ISP). Services are delivered by providers contracted with managed care organizations (MCOs) to provide those services. The MCO completes all initial and annual service planning activities, and verifies, authorizes, coordinates and monitors services.

STAR Kids members may choose from three service delivery options for the delivery of certain long term services and supports (LTSS). The options are agency, service responsibility, and consumer directed. State plan LTSS which can be delivered through these service delivery options are:

- Community First Choice habilitation (CFC HAB);
- Community First Choice personal assistance (CFC PAS); and
- Personal care services (PCS).

STAR Kids members receiving Medically Dependent Children Program (MDCP) services may choose from these service delivery options for the following services:

- Employment assistance;
- Flexible family support services;
- Respite; and
- Supported employment.

STAR Kids members or their legally authorized representatives (LARs) may choose to participate in the agency option, consumer-directed services (CDS) or service responsibility option (SRO) delivery models. Members who choose the agency model select an MCO-contracted agency to coordinate service delivery for the services on their ISP. Members who

choose CDS are given the authority to self-direct certain services. If the member chooses to self-direct certain services, the MCO coordinates delivery of non-member-directed services.

In the SRO model, an agency is the attendant's employer and handles the business details (for example, paying taxes and doing the payroll). The agency also orients attendants to agency policies and standards before sending them to members' homes. The member or their LAR is responsible for most of the day-to-day management of the attendant's activities, beginning with interviewing and selecting the person who will be the attendant.

In the CDS model, the member or LAR, with assistance from a financial management service agency (FMSA), ensure all supplies necessary to provide all authorized services.. These personnel may be employed directly by or through personal service agreements or subcontracts with the providers.

More information about these service delivery options is available in Section 5000, Service Delivery Options.

1300 Service Coordination

All STAR Kids members have access to service coordination from their managed care organization (MCO). The MCO may employ service coordinators, but may also enter into an arrangement with an integrated health home that offers service coordinators to provide some service coordination functions through the member's health home. To integrate the member's care while remaining informed of the member's needs and condition, the service coordinator must actively involve the member's primary and specialty care providers, including behavioral health service providers, and providers of non-capitated services and non-covered services. When members or their legally authorized representatives (LAR) request information regarding a referral to a nursing or other long-term care facility, the service coordinator must inform the member or LAR about options available through home and community based service (HCBS) programs, in addition to facility-based options.

MCO service coordinators are responsible for assessing a member's needs using the STAR Kids Screening and Assessment Instrument (SK-SAI), developing an individual service plan (ISP) for every member, and authorizing services identified on the ISP. During the annual face-to-face visit, the service coordinator must:

- Review the member's current short-term and long-term goals and objectives, as documented in the ISP;
- Acknowledge and document goals and objectives the member has achieved or with which the member has made progress;
- Acknowledge and document goals and objectives that may need to be adjusted;
- Develop new goals and objectives with input from the member, member's family, and member's providers;
- Update the member's ISP;
- Assist with development and management of the ISP and budget for members receiving Medically Dependent Children Program (MDCP) services;
- Inform members receiving long term services and supports about the consumer directed services and service responsibility options;

- Educate the member and member’s LAR about their rights regarding acts that constitute Abuse or Neglect (Child Protective Services) and Abuse, Neglect, or Exploitation (Adult Protective Services); and
- Review member rights and MCO processes for service authorization, appeals, and complaints.

1310 Service Coordination Requirements

Managed care organizations (MCOs) provide a different level of service coordination, depending on a member's needs. Members with more complex needs receive more service coordination than members whose needs are less complex.

Members with the highest needs are designated as level 1 members in the STAR Kids Managed Care Contract. These members receive a minimum of four face-to-face visits from a named service coordinator annually, in addition to monthly phone calls, unless otherwise requested by a member or the member's legally authorized representative (LAR). Level 1 service coordinators must be a registered nurse (RN), nurse practitioner (NP), a physician's assistant (PA), a licensed social worker (LSW), or licensed professional counselor (LPC) if the member's service needs are primarily behavioral. Level 1 members include those who:

- Are enrolled in the Medically Dependent Children Program (MDCP) or Youth Empowerment Services (YES) waiver;
- Have complex needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year);
- Are diagnosed with severe emotional disturbance (SED) or serious and persistent mental illness (SPMI); or
- Are at risk for institutionalization.

Level 2 members have specialized needs that are less complex than level 1 members. Level 2 members receive a minimum of two face-to-face visits and six telephonic contacts annually from a named service coordinator, unless otherwise requested by the member or their LAR. Level 2 service coordinators must be either an RN, NP, PA, have an undergraduate or graduate degree in social work or a related field, or be a licensed vocational nurse (LVN) with previous service coordination or case management experience. Level 2 members include:

- members who do not meet the requirements for level 1 but receive long term services and supports;
- members the MCO believes would benefit from a higher level of service coordination based on results from the SK-SAI and additional MCO findings;
- members with a history of substance abuse (multiple outpatient visits, hospitalization, or institutionalization within the past year); or
- members without SED or SPMI, but who have another behavioral health condition that significantly impairs function.

Level 3 members have fewer needs than level 2 members. MCOs are required to provide level 3 members with one face-to-face visit, in which the SK-SAI is completed, and make three telephonic contacts annually, at minimum. Level 3 service coordinators must have a minimum of a high school diploma or a general education diploma (GED) and direct experience working with children and young adults with similar conditions or behaviors in three of the last five years.

Members receiving level 1 or level 2 service coordination must have a single, named person as their assigned service coordinator. Level 3 members, or their LAR, may request a single named service coordinator by calling the service coordination hotline on the back of their STAR Kids member ID card. In addition, the MCO must provide a named Service Coordinator for Members who qualify for Level 3 who reside in a nursing facility or community-based ICF/IID or who are served by one of the following non-capitated 1915(c) waivers: Community Living Assistance Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community Based Services (HCBS), or Texas Home Living (TxHmL). The MCO must notify members within five (5) business days of the name and phone number of their new service coordinator, if their service coordinator changes.

MCOs must notify in writing all members of:

- The name of their service coordinator;
- The phone number of their service coordinator;
- The minimum number of contacts they will receive every year; and
- The types of contacts they will receive.

1320 Service Coordination and Programs Serving Members with Intellectual or Developmental Disabilities

Members who have intellectual or developmental disabilities (IDD) living in a community-based Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF-IID) or who receive services through one of the following IDD waivers receive their acute care services and some long term services supports (LTSS) (e.g., private duty nursing) through STAR Kids and continue to receive most of their LTSS through the following programs:

- Community Living Assistance Support Services (CLASS),
- Deaf Blind with Multiple Disabilities (DBMD),
- Home and Community-based Services (HCS),
- Texas Home Living (TxHmL),
- Community intermediate care facilities for individuals with intellectual disabilities or related conditions (ICF/IIDs).

Members with IDD that meet the above criteria have a named managed care organization (MCO) service coordinator. The number of required service coordination visits or telephone calls and level of service coordination varies by acuity and the member’s or their legally authorized representative’s (LAR’s) personal preference.

These members also have a person(s) outside of the MCO who develops and implements a service plan and monitors LTSS service delivery. The MCO service coordinator must respond to requests from the member's waiver case manager or service coordinator. The member’s waiver case manager or service coordinator should invite MCO service coordinators to their care planning meetings or other interdisciplinary team meetings, as long as the member does not object. These meetings are not mandatory but are strongly recommended and participation may be in person or telephonically. The MCO service coordinator is responsible for the coordination of these member's acute care services and capitated LTSS.

1330 Service Coordination and the Youth Empowerment Services Program

Members who receive services through the Youth Empowerment Services (YES) program receive their acute care services and some long term services and supports (LTSS) (e.g., day activity and health services (DAHS), private duty nurse (PDN), and community first choice (CFC) only through STAR Kids and continue to receive their waiver services through the YES program. Members served by the YES program will have a named managed care organization (MCO) service coordinator and will be considered level 1 members.

These members also have a case manager outside of the MCO who develops and implements a YES service plan and monitors waiver service delivery. This case management is provided through the capitated Mental Health Targeted Case Management (MH TCM) benefit, which the MCO must authorize for any member receiving YES. The MCO service coordinator must respond to requests from the member's waiver case manager. The member's waiver case manager should invite MCO service coordinators to their care planning meetings or other interdisciplinary team meetings, as long as the member does not object. These meetings are not mandatory but are strongly recommended and participation may be either in person or telephonically. The MCO service coordinator is responsible for the coordination of these member's acute care services and capitated LTSS.

1340 Service Coordinators and Home and Community Based Services- Adult Mental Health

The Home and Community Based Services-Adult Mental Health program (HCBS-AMH) serves individuals who have serious and persistent mental illness (SPMI) and: a history of extended (three cumulative or consecutive years of the past five) institutional stays in psychiatric facilities; individuals with severe mental illness (SMI) and frequent visits to the emergency department; and, individuals with SMI and frequent arrests and stays in a correctional facility. HCBS-AMH provides an array of enhanced community-based services, including residential assistance, targeted to the program's population. HCBS-AMH is operated on a fee-for-service basis for individuals aged 18 and up. Each participant is assigned a Recovery Manager (RM), who monitors and coordinates HCBS-AMH services through recovery plan meetings. Members enrolled in HCBS-AMH receive their acute care services through their managed care organization (MCO) and their enhanced community-based services from providers contracted with Department of State Health Services (DSHS). Additional information about HCBS-AMH can be found here: https://www.dshs.state.tx.us/mhsa/hcbs-amh/

Program Point of Contact:

Each managed care organization (MCO) must have a designated Program Point of Contact (PPOC) for the adult mental health (AMH) Program. The PPOC is responsible for the following:

- Ensuring MCO service coordinators are aware of home and community based services - adult mental health (HCBS-AMH) services offered and their coordination responsibilities; and
- Responding within 3 business days to concerns from Texas Health and Human Services Commission (HHSC) or Recovery Managers (RM) to mitigate any issues with service coordination including uncooperative MCO service coordinators, missed teleconferences, or other concerns regarding MCO participation in the AMH Program.

MCO Service Coordination Responsibility:

MCO service coordinators must participate in telephonic recovery plan meetings, as scheduled by HHSC or RMs, and provide any requested member-specific information prior to the meeting. Service coordinators must:

- Send requested information to the RM or Texas Health and Human Services Commission (HHSC) three business days prior to the scheduled recovery plan meeting. This information includes, but is not limited to the following:
    - Updates regarding member condition;
    - Sharing relevant authorizations, such as an authorization or provider contact information when an HCBS-AMH member receives Community First Choice (CFC) services;
    - Upcoming MCO service coordinator face-to-face appointments and/or scheduled dates for telephonic contacts with the member; and
    - Relevant member treatment documents as requested by RM or HHSC.
- Respond to ad-hoc requests from RM or HHSC with "urgent" in the subject line within 1 business day.
- Respond to non-urgent ad-hoc requests in a timely manner.
- Coordinate with HHSC and RM when a member transitions in to or out of HCBS-AMH.

HCBS-AMH may provide transitional planning for individuals who reside in an institution and also enrolled in a STAR Kids MCO. MCO service coordinators must participate in planning meetings with RM, telephonically or in-person, during the member's stay. Planning meetings focus on coordination of services upon discharge from the inpatient psychiatric institution. MCO service coordinators are responsible for providing RM requested treatment information for transition planning purposes. STAR Kids MCOs must follow all discharge planning requirements as outlined in STAR Kids Managed Care Contract, Section 8.1.38.10.

1350 Service Coordinators and the Section 811 Project Rental Assistance Program

Reserved

1400 Medically Dependent Children Program

The Medically Dependent Children Program (MDCP) is a home and community based services program authorized under §1915(c) of the Social Security Act. MDCP provides respite, flexible family support services, minor home modifications, adaptive aids, transition assistance services, employment assistance, supported employment, and financial management services through a STAR Kids managed care organization (MCO). The purpose of this section is to provide an overview of MDCP, including its eligibility requirements.

1410 Program Goal

The goal of the Medically Dependent Children Program (MDCP) is to support families caring for children and young adults age 20 and younger who are medically dependent, and to encourage de-institutionalization of children and young adults who reside in nursing facilities.

MDCP accomplishes this goal by:

- enabling children and young adults who are medically dependent to remain safely in their homes;
- offering cost-effective alternatives to placement in nursing facilities and hospitals; and
- Supporting families in their role as the primary caregiver for their children and young adults who are medically dependent.

1500 Medically Dependent Children Program Eligibility

Individuals become eligible to be assessed for Medically Dependent Children Program (MDCP) services when their name comes to the top of the MDCP interest list. Individuals may be placed on the interest list on a first come-first served basis by contacting Texas Health and Human Services Commission (HHSC) or their managed care organization (MCO) if they are already enrolled in STAR Kids. Once an individual's name comes to the top of the list, determination of eligibility begins as the individual applies for services. Individuals not already enrolled in STAR Kids are referred to as applicants. Individuals enrolled in STAR Kids who are assessed for MDCP are referred to as members.

MDCP is provided by virtue of authority granted to the state of Texas to allow delivery of long-term services and supports (LTSS) that assist members to live in the community in lieu of a nursing facility. To be eligible for services under the MDCP waiver, the applicant or member must meet the following criteria:

- medical necessity for a nursing facility level of care;
- have an individual service plan with services under the established cost limit;
- have an unmet need for at least one monthly waiver service;
- be birth through age 20;
- be a United States citizen and Texas resident;
- be in an appropriate living situation; and
- have full Medicaid eligibility.

1510 Medical Necessity Determination

A Medically Dependent Children Program (MDCP) waiver applicant/member must have a valid medical necessity (MN) determination before admission into the MDCP waiver. The determination of MN is based on a completed STAR Kids Screening and Assessment Instrument (SK-SAI). The applicant's/member's individual service plan (ISP) cost limit is calculated based on information gathered through the SK-SAI MDCP module
.
The managed care organization (MCO) completes and submits the SK-SAI to Texas Medicaid & Healthcare Partnership (TMHP) for MDCP applicants/members. TMHP processes the SK-SAI for applicants/members to determine MN and calculate a Resource Utilization Group (RUG). A RUG is a measure of nursing facility staffing intensity and is used in waiver programs to:

- categorize needs for applicants/members; and
- establish the service plan cost limit.

When TMHP processes a SK-SAI, a three-alphanumeric digit RUG is generated and appears in the TMHP Long Term Care (LTC) online portal as well as the MCO's response file. An SK-SAI with incomplete RUG information results in a "BC1" code instead of a RUG value. An SK-SAI

resulting in a BC1 code does not have all of the information necessary for TMHP to accurately calculate a RUG for the member. Code BC1 is not a valid RUG to determine MDCP eligibility.

The MCO must correct the information on the SK-SAI within 14 calendar days of submitting the assessment that resulted in a BC1 code. The MCO nurse must also submit any corrections to SK-SAI items used to determine MN within 14 days. After 14 calendar days, the MCO must inactivate the SK-SAI and resubmit the assessment with correct information to TMHP. Please see Appendix I, SK-SAI and SK-ISP, for detailed instructions pertaining to communicating corrections and inactivations to the SK-SAI to TMHP.

Applicants without Medicaid require Medicaid eligibility financial determination. For these individuals, the HHSC Program Support Unit (PSU) must notify the Medicaid for the Elderly and People with Disabilities (MEPD) specialist that the applicant meets MN. This notification may be by telephone or may be documented on Form H1746-A, MEPD Referral Cover Sheet, which the PSU sends to the MEPD specialist. The MEPD specialist may view the LTC online portal to confirm that the applicant/member has met the MN criteria. This process is outlined in more detail in Section 2110, Managed Care Organization Selection.

1511 Medical Necessity Determination for Applicants/Members Residing in Nursing Facilities

During initial contact with the applicant/member, the service coordinator must explore the applicant/member's status in the nursing facility (NF) and desire to transition to the community. The service coordinator completes the STAR Kids Screening and Assessment Instrument (SK-SAI) and submits the assessment to Texas Medicaid & Healthcare Partnership (TMHP) indicating a request for a determination of medical necessity. This process is described in more detail in Appendix I, SK-SAI and SK-ISP.

1512 Medical Necessity Determination for Applicants/Members Not Residing in Nursing Facilities

For applicants/ members not living in nursing facilities (NF), the medical necessity determination is made by Texas Medicaid & Healthcare Partnership (TMHP) based on the STAR Kids Screening and Assessment Instrument (SK-SAI) completed by the managed care organization (MCO) selected by the applicant/member.

The MCO must electronically submit the SK-SAI to TMHP indicating a request for medical necessity determination after obtaining a physician signature using Form 2601, Physician Certification. The SK-SAI and Physician Certification must be retained in the MCO’s records.

1520 Individual Cost Limit

The cost of Medically Dependent Children Program (MDCP) waiver services cannot exceed 50 percent of the cost of care the state would pay if the member was served in a nursing facility (NF). For initial eligibility, the MDCP waiver applicant must have an individual service plan (ISP) of MDCP services developed that is at or below 50 percent of what the cost to provide services to that individual, based on their Resource Utilization Group (RUG) in a nursing facility.

For initial applications, the total cost of services for an applicant's MDCP services ISP must be equal to or below the individual's ISP cost limit. Applicants exceeding the cost limit cannot elect

to receive reduced services for entry to the program if the Medicaid state plan services and their MDCP services this would pose a risk to the individual's health, safety and welfare.

1530 Unmet Need for at Least One Waiver Service

The Code of Federal Regulations (CFR) specifies individuals are not eligible to receive Medically Dependent Children Program (MDCP) waiver services unless they have a need for at least one waiver service delivered monthly. For initial and continued eligibility for the MDCP, a member must have an unmet need for, and therefore use, at least one MDCP waiver service each month. Therefore, a MDCP waiver individual service plan (ISP) which has $0.00 as the "Total Est. Waiver Cost" at the bottom of Form 2604, STAR Kids ISP will be rejected. Members who do not use at least one MDCP waiver service per month are subject to disenrollment from the waiver. For members without Supplemental Security Income (SSI) (i.e., Medical Assistance Only (MAO) members), disenrollment from the MDCP waiver may result in a loss of Medicaid eligibility.

1540 Age

To be eligible to participate in the Medically Dependent Children Program (MDCP) waiver an applicant/member must be under 21 years of age.

1550 Citizenship

As part of Public Law 109-171, Deficit Reduction Act of 2005, each U.S. citizen eligible for Medicaid is required to provide proof of U.S. citizenship and identity. This requirement affects all long-term services and supports (LTSS) members whose financial eligibility is based on a determination from Medicaid for the Elderly and People with Disabilities (MEPD) staff. MEPD also verify an applicant is a Texas resident.

1560 Living Arrangement

Managed care organization (MCO) service coordinators must confirm that the applicant/member, if under age 18, lives with a family member such as a parent, guardian, grandparent or sibling as defined in the Glossary. The MCO service coordinator must review guardianship documentation or obtain a statement from the applicant/member or family member regarding relation. The service coordinator must maintain this documentation in the member's case file.

1570 Financial Eligibility

Applicants/members who receive Supplemental Security Income (SSI) are already eligible for Medicaid and will not require a financial or Medicaid eligibility decision. The Social Security Administration (SSA) has already made this determination. Program Support Unit (PSU) must determine if an applicant/member is currently on Medicaid and check Texas Integrated Eligibility Redesign System (TIERS) to confirm the current status of an applicant/member. A Medicaid for the Elderly and People with Disabilities (MEPD) determination may have already been completed for a member and must be used unless there have been changes in the applicant's financial situation.

If the applicant does not have a Medicaid eligibility determination, it is the PSU's responsibility to assist the applicant with completing the application and obtaining the necessary verifications to establish eligibility from the MEPD Division. These processes are described in Section 2100, Enrollment Following Release from the Interest List.

1600 Disclosure of Information

1610 Confidential Nature of a Case Record

Information collected in determining initial or continuing eligibility is confidential. The restriction on disclosing information is limited to information about individual members. The Health and Human Services Commission (HHSC) and the managed care organization (MCO) may disclose general information about policies, procedures or other methods of determining eligibility, and any other information that is not about or does not specifically identify a member. A member or their legally authorized representative (LAR) may review all information in the case record and in HHSC or MCO handbooks that contributed to the decision about eligibility.

1611 Establishing Identity for Contact Outside the Interview Process

Keep all information that the Health and Human Services Commission (HHSC) and the managed care organization (MCO) have about a member or any individual on the member's case confidential. Confidential information includes, but is not limited to, individually identifiable health information.

Before discussing or releasing information about a member or any individual on the member's case, take steps to be reasonably sure the individual receiving the confidential information is either the member or an individual the member has authorized to receive confidential information (for example, an attorney or personal representative).

1611.1 Telephone Contact

Establish the identity of an individual who identifies himself as a member by using the individual’s knowledge of the member's:

- Social Security number (SSN);
- date of birth; or
- other identifying information.

Establish the identity of a personal representative by using the individual's knowledge of the member's:

- SSN;
- date of birth;
- other identifying information; or
- knowledge of the same information about the member's representative.

Establish the identity of attorneys or legal representatives by asking for the individual to provide Form 1826-D, Case Information Release, completed and signed by the member. The managed care organization (MCO) must maintain this documentation in the member's case file.

Health and Human Services Commission (HHSC) staff must use established regional procedures to confirm the identity of legislators or their staff. The MCO must use established HHSC procedures to confirm the identity of legislators or their staff.

1611.2 In-Person Contact

Establish the identity of the individual who presents himself as a member or member's representative at a Health and Human Services Commission (HHSC) or managed care organization (MCO) office by using sources such as:

- driver license;
- date of birth;
- SSN; or
- other identifying information.

Establish the identity of other HHSC/MCO staff, federal agency staff, researchers or contractors by using sources such as:

- employee badge; or
- government-issued identification card with a photograph.

Identify the need for other HHSC/MCO staff, federal staff, research staff or contractors to access confidential information through:

- official correspondence or a telephone call from a state or regional office; or
- contact with an HHSC attorney.

Contact appropriate regional or state office staff when federal agency staff, contractors, researchers or other HHSC/MCO staff come to the office without prior notification or adequate identification and request permission to access records.

1611.3 Verification and Documentation

If disclosing individually identifiable health information, document and maintain documentation in the member's case file information pertaining to how the identity of the person was verified when contact is outside the interview.

Verify the identity of the person who requests disclosure of individually identifiable health information using sources such as:

- valid driver license or Department of Public Safety (DPS) identification card;
- birth certificate;
- hospital or birth record;
- adoption papers or records;
- work or school identification card;
- voter registration card;
- wage stubs; and
- U.S. passport.

1612 Custody of Records

Records must be safeguarded. Use reasonable diligence to protect and preserve records and to prevent disclosure of the information they contain, except as provided by Health and Human Services Commission (HHSC) and managed care organization (MCO) regulations.

Reasonable diligence for employees responsible for records includes keeping records:

- in a locked office when the building is closed;
- properly filed during office hours; and
- in the office at all times, except when authorized to remove or transfer them.

1613 Disposal of Records

To dispose of documents with member-specific information, Health and Human Services Commission (HHSC) staff must follow established procedures for destruction of confidential data. Managed care organizations (MCOs) must follow procedures contained in Section 7.06 of the STAR Kids Managed Care Contract.

1614 When and What Information May Be Disclosed

Reasonable efforts must be made to limit the use, request or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program. The disclosure of individual medical information from Health and Human Services Commission (HHSC) and managed care organization (MCO) records must be limited to the minimum necessary to accomplish the requested disclosure. For example, if a member authorizes release of income verification, including disability income, do not release related case medical information unless specifically authorized by the member.

Give member addresses or other case information only to a person who has written permission from the member to obtain the information. The member authorizes the release of information by completing and signing:

- Form 1826-D, Case Information Release; or
- a document containing all of the following information:
    - the applicant's/member's:
        - full name (including middle initial) and Medicaid identification number; or
        - full name (including middle initial) and either date of birth or social security number (SSN);
    - a description of the information to be released. **Note:** If a general release is authorized, provide the information that can be disclosed to the member. Withhold confidential information from the case record, such as names of persons who disclosed information about the household without the household's knowledge, and the nature of pending criminal prosecution;
    - a statement specifically authorizing HHSC or the MCO to release the information;
    - the name of the person or agency to whom the information will be released;
    - the purpose of the release;
    - an expiration event that is related to the member, the purpose of the release or an expiration date of the release;

- a statement about whether refusal to sign the release affects eligibility for delivery of services;
- a statement describing the applicant's or member's right to revoke the authorization to release information;
- the date the document is signed; and
- the signature of the applicant or member.

Note: If the case information to be released includes individually identifiable health information, the document must also tell the applicant or member that information released under the document may no longer be private, and may be released further by the person receiving the information.

Occasionally requests for information from the case records of deceased members are received. In these instances, protect the confidentiality of the former members and their survivors.

The Office of the General Counsel at HHSC handles questions about the release of information under the Open Records Act. All questions and problems encountered by individuals concerning release of information should be referred to these offices. MCO staff should contact HHSC's MCO.

1615 Confidential Nature of Medical Information

Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets additional standards to protect the confidentiality of individually identifiable health information. Individually identifiable health information is information that identifies or could be used to identify an individual and that relates to the:

- past, present or future physical or behavioral health or condition of the individual;
- provision of health care to the individual; or
- past, present or future payment for the provision of health care to the individual.

1616 Privacy Notice

Health and Human Services Commission (HHSC) and managed care organization (MCO) staff must send each member the Health and Human Services Agencies' Notice of Privacy Practices (links below), upon certification. This notice tells the member about:

- his/her privacy rights;
- the duties of HHSC and the MCO to protect health information; and
- how HHSC and the MCO may use or disclose health information without his/her authorization. (Examples of use or disclosure include health care operations (for example, Medicaid), public health purposes, reporting victims of abuse, law enforcement purposes, sharing with HHSC/MCO contractors and coordinating government programs that provide benefits.)

Link to printable English PDF
Link to printable Spanish PDF

1617 Member Authorization

The member may authorize the release of health information from Health and Human Services Commission (HHSC) and managed care organization (MCO) records by using a valid authorization form. Form 1826-D, Case Information Release, includes all the authorization elements required by Health Insurance Portability and Accountability Act (HIPPA) privacy regulations.

1618 Minimum Necessary Information Release

Reasonable efforts must be made to limit the use, request or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program. The disclosure of individual medical information from Health and Human Services Commission (HHSC) and managed care organization (MCO) records must be limited to the minimum necessary to accomplish the requested disclosure. For example, if a member authorizes release of income verification, including disability income, do not release related case medical information unless specifically authorized by the member.

1619 Personal Representatives

Only the member's personal representative can exercise the member's rights with respect to individually identifiable health information. Therefore, only a member's personal representative may authorize the use or disclosure of individually identifiable health information or obtain individually identifiable health information on behalf of a member. Exception: Health and Human Services Commission (HHSC) and the managed care organization (MCO) are not required to disclose the information to the personal representative if the member is subjected to domestic violence, abuse or neglect by the personal representative. Consult appropriate legal counsel, as described in Section 1614, When and What Information May Be Disclosed, if it is believed that health information should not be released to the personal representative.

Note: A responsible party is not automatically a personal representative.

1619.1 Adults and Emancipated Minors

If the member is an adult or emancipated minor, including married minors, the member's personal representative is a person who has the authority to make health care decisions about the member and includes a:

- person the member has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney with the authority to make health care decisions;
- court-appointed guardian for the member; or
- person designated by law to make health care decisions when the member is in a hospital or nursing home and is incapacitated or mentally or physically incapable of communication.

Consult appropriate legal counsel, as described in Section 1614, When and What Information May Be Disclosed, for approval.

1619.2 Unemancipated Minors

A parent is the personal representative for a minor child except when:

- the minor child can consent to medical treatment by himself/herself. Under these circumstances, do not disclose to a parent information about the medical treatment to which the minor child can consent. A minor child can consent to medical treatment by himself/herself when the:
    - minor is on active duty with the U.S. military;
    - minor is age 16 or older, lives separately from the parents and manages his/her own financial affairs;
    - consent involves diagnosis and treatment of disease that must be reported to the local health officer or the Texas Department of State Health Services (DSHS);
    - minor is unmarried and pregnant and the treatment (other than abortion) relates to the pregnancy;
    - minor is age 16 years or older and the consent involves examination and treatment for drug or chemical addiction, dependency or use at a treatment facility licensed by DSHS;
    - consent involves examination and treatment for drug or chemical addiction, dependency or use by a physician or counselor at a location other than a treatment facility licensed by the State;
    - minor is unmarried, is the parent of a child, has actual custody of the child and consents to treatment for the child; or
    - consent involves suicide prevention or sexual, physical or emotional abuse.
- a court is making health care decisions for the minor child or has given the authority to make health care decisions for the minor child to an adult other than a parent or to the minor child. Under these circumstances, do not disclose to a parent information about health care decisions not made by the parent.

1619.3 Deceased Individuals

The personal representative for a deceased member is an executor, administrator or other person with authority to act on behalf of the member or the member's estate. These include:

- an executor, including an independent executor;
- an administrator, including a temporary administrator;
- a surviving spouse;
- a child;
- a parent; and
- an heir.

Consult appropriate legal counsel, as described in Section 1614, When and What Information May Be Disclosed, if you have questions about whether a particular person is the personal representative of an applicant or member.

1620 Confidential Information on Notifications

The Health and Human Services Commission (HHSC) is committed to protecting all confidential information supplied by the applicant or individual during the eligibility determination process.

This includes inclusion of confidential information by HHSC staff to third parties who receive a copy of a notification of eligibility form.

Staff must ensure they do not include confidential information on the eligibility notice that should not be shared with the service provider or another third party. For example:

- Notification is received from Medicaid for the Elderly and People with Disabilities (MEPD) that the member has lost Medicaid because his income of $2,892 exceeds the eligibility limit of $2,022. It is a violation of confidentiality to record on Form H2065-D, Notification of STAR Kids Managed Care Program Services, "Your income of $2,892 exceeds the eligibility limit of $2,022." The comment should simply state, "You are no longer eligible for Medicaid."
- Another applicant is being denied Medically Dependent Children Program (MDCP) services because the presence of weapons in his home presents a hazard to service providers. It is a violation of confidentiality to record on H2065-D, "The presence of weapons in your home presents a hazard to service providers." The comment should simply state, "Your services are being denied due to hazardous conditions in your home."

In the examples above, revealing specifics of the individual's income or the condition of his home environment is a violation of his right to confidentiality. In all cases, HHSC staff must assess any information provided by the individual to determine if its release would be a confidentiality violation.

1630 Correcting Information

A member or their legally authorized representative has a right to correct any information that the Health and Human Services Commission (HHSC) or the managed care organization (MCO) has about the member and any other individual on the member's case.

A request for correction must be in writing and:

- identify the individual asking for the correction;
- identify the disputed information about the individual;
- state why the information is wrong;
- include any proof that shows the information is wrong;
- state what correction is requested; and
- include a return address, telephone number or email address at which HHSC or the MCO can contact the individual.

If HHSC or the MCO agrees to change individually identifiable health information, the corrected information is added to the case record, but the incorrect information remains in the file with a note that the information was amended per the member's request.

Notify the member in writing within 60 days (using current agency letterhead) that the information is corrected, or will not be corrected, and the reason. Inform the member if HHSC/MCO needs to extend the 60-day period by an additional 30 days to complete the correction process or obtain additional information.

If HHSC or the MCO makes a correction to individually identifiable health information, they must ask the member for permission before sharing with third parties. The agency will make a reasonable effort to share the correct information with persons who received the incorrect information if they may have relied or could rely on it to the disadvantage of the member. HHSC staff must follow regional procedures to contact the HHSC privacy officer for a record of disclosures. MCOs must follow HHSC procedures as stated in the STAR Kids Managed Care Contract.

Note: Do not follow above procedures when the accuracy of information provided by a member is determined by another review process, such as a:

- fair hearing;
- civil rights hearing; or
- other appeal process.

The decision in that review process is the decision on the request to correct information.

1640 Communication with the Managed Care Organization

In order to comply with the Health Insurance Portability and Accountability Act (HIPAA), it is imperative for a member's individually identifiable health information to be shared only with his or her selected managed care organization (MCO). This makes it crucial that when documents containing member information are posted in the incorrect MCO folder in TxMedCentral, they be corrected immediately upon realization an error was made.

Send notification of all posting errors to the Program Support Unit (PSU). Include the document identifying information, the name of the folder in which it was erroneously posted and the name of the folder into which it should have been posted. Include the time the correction was made.

Example: Posted XX_2067_123456789_ABCD_IM_MFP.doc in SUPSKW at 8:54 a.m. on December 20. Should have been posted to MOLSKW. Corrected at 9:22 a.m. December 20.

All emails containing member information must be sent using encryption software. No individually identifiable information may appear in the subject line.
See also:

- Section 1615, Confidential Nature of Medical Information – HIPAA; and
- Section 5100, Agency Option (AO)

1650 Alternate Means of Communication

The Health and Human Services Commission (HHSC) and the managed care organization (MCO) must accommodate a member's reasonable requests to receive communications by alternative means or at alternate locations.

The member must specify in writing the alternate mailing address or means of contact, and include a statement that using the home mailing address or normal means of contact could endanger the member.

1700 Citizenship and Identity Verification

As part of Public Law 109-171, Deficit Reduction Act of 2005, each U.S. citizen eligible for Medicaid is required to provide proof of U.S. citizenship and identity. This requirement affects all long-term services and supports (LTSS) members whose financial eligibility is based on a determination from Medicaid for the Elderly and People with Disabilities (MEPD) staff.

This documentation must be provided at the initial determination. Verification of citizenship and identity for eligibility purposes is a one-time activity as documented in the MEPD Handbook, Chapter D-5000, Citizenship and Identity. Once verification of citizenship is established and documented by MEPD staff, verification is no longer required even after a break in eligibility.

1710 Acceptable Documentation for Both Citizenship and Identity

1711 Supplemental Security Income Recipients

The State Data Exchange (SDX) contains the needed information to verify citizenship. For any active Supplemental Security Income (SSI) recipient, Medicaid for the Elderly and People with Disabilities (MEPD) staff are able to use the SDX as verification for both citizenship and identity. For any denied SSI recipient, the SDX can be used as a valid verification source of both citizenship and identity when the denial is for any reason other than citizenship. The SDX printout shows action code N13 if the denial is for citizenship.

1712 Medicare Recipients

Active Medicare recipients are exempt from the requirement to provide evidence of citizenship and identity. The Social Security Administration (SSA) documents citizenship and identity for Medicare recipients.

For any individual entitled to or enrolled in Medicare Part A or B and subsequently denied Medicare, use the State On-Line Query (SOLQ) system or Wire Third Party Query (WTPY) system as documentation of both citizenship and identity when the denial is for any reason other than citizenship. If there is an end date listed for Medicare, the individual must provide documentation on the loss of Medicare.

1713 All Other Individuals

The primary documents that may be accepted as proof of both identity and citizenship include:

- U.S. passport;
- Certificate of Naturalization (N-550 or N-570); or
- Certificate of U.S. Citizenship (N-560 or N-561).

If an individual does not provide one of these primary documents that establish both U.S. citizenship and identity, the individual must provide two documents:

- one document that establishes U.S. citizenship; and
- one document that establishes identity.

See Evidence of Identity below for a list of documents that are acceptable.

Documents that establish citizenship are divided into second, third and fourth levels based on the reliability of the evidence.

Primary Evidence of Citizenship and Identity
• U.S. passport. • Certificate of Naturalization. • Certificate of U.S. Citizenship. • State Data Exchange (SDX) for denied Supplemental Security Income (SSI) recipients when the denial reason is for any reason other than citizenship (N13). • State On-Line Query (SOLQ)/Wire Third Party Query (WTPY) and documentation on reason for Medicare denial.

Begin with the second level of evidence of citizenship and continue through the levels to locate the best available documentation.

Second Level of Evidence of Citizenship **(Use only when primary evidence is not available.)**
• A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after Jan. 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (if born on or after Jan. 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (if born after Nov. 4, 1986). Contact the Bureau of Vital Statistics (BVS) for an individual born in Texas. If an individual's date of birth is earlier than 1903 or if the birth was out of state, accept a legible, non-questionable copy. For a birth out of state, individuals may obtain a birth certificate through the following: BirthCertificate.com; vitalchek.com; and usbirthcertificate.net or their toll-free number, 1-888-736-2692. • Report of Birth Abroad of a U.S. Citizen (FS-240). • Certification of Birth Abroad (FS 545 or DS-1350). • U.S. Citizen Identification card (Form I-179 or I-197). • Northern Mariana Identification card (I-873). • American Indian card (I-872) issued by the Department of Homeland Security with classification code "KIC". • Final adoption decree showing the child's name and U.S. place of birth. • Evidence of U.S. Civil Service employment before June 1, 1976. • U.S. military record showing a U.S. place of birth (Example: DD-214).
Third Level of Evidence of Citizenship **(Use only when primary and second level evidence is not available.)**
• Hospital record of birth showing the U.S. place of birth. • Life, health or other insurance record showing the U.S. place of birth.

- Religious record of birth recorded in the U.S. or its territories within three months of birth that indicates a U.S. place of birth showing either the date of birth or the individual's age at the time the record was made.
- Early school record showing a U.S. place of birth, name of the child, date of admission to the school, date of birth, and the name(s) and place(s) of birth of the applicant's/recipient's parents.

Fourth Level of Evidence of Citizenship
(Use only when primary, second and third level evidence is not available.)

Any listed documents used must include biographical information, including U.S. place of birth.

- Federal or state census record showing U.S. citizenship or a U.S. place of birth and the individual's age (generally for individuals born 1900-1950).
- Seneca Indian Tribal census record showing a U.S. place of birth.
- Bureau of Indian Affairs Tribal census records of the Navajo Indians showing a U.S. place of birth.
- Bureau of Indian Affairs Roll of Alaska Natives.
- U.S. state vital statistics official notification of birth registration showing a U.S. place of birth.
- Statement showing a U.S. place of birth signed by the physician or midwife who was in attendance at the time of birth.
- Institutional admission papers from a nursing facility, skilled care facility or other institution showing a U.S. place of birth.
- Medical (clinic, doctor or hospital) record, excluding an immunization record, showing a U.S. place of birth.
- Affidavits from two adults regardless of blood relationship to the individual. (Use only as a last resort when no other evidence is available.)

Evidence of Identity

- Driver license issued by a state either with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color.
- School identification card with a photograph.
- U.S. military card or draft record.
- Identification card issued by the federal, state or local government with the same information that is included on a driver license
- Department of Public Safety identification card with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color.
- Birth certificate.
- Hospital record of birth.

- Military dependent's identification card.
- Native American Tribal document.
- U.S. Coast Guard Merchant Mariner card.
- Certificate of Degree of Indian Blood or other U.S. American Indian/Alaskan Native and Tribal document with a photograph or other personal identifying information.
- Data matches with other state or federal government agencies (Example: Employee Retirement System and Teacher Retirement System).
- Three or more supporting documents such as a marriage license, divorce decree, high school diploma or employer identification card (use only with second and third level evidence of citizenship).
- Adoption papers or records.
- Work identification card with photograph.
- Signed application for Medicaid (accept signature of an authorized representative or a responsible person acting on the individual's behalf).
- Health care admission statement.
- For children under age 16, school records (may include nursery or day care records).
- For children under age 16, doctor, clinic or hospital records.
- For children under age 16, an affidavit signed by a parent or guardian stating the date and place of birth of the child (use as a last resort when no other evidence is available and if an affidavit is not used to establish citizenship).
- For disabled individuals in residential care facilities who cannot provide any document on this list, an affidavit signed by the facility director or administrator attesting the identity of the individual (use as a last resort when no other evidence is available and if an affidavit is not used to establish citizenship).

In the hierarchy of approved documentation sources, some documents listed to verify citizenship are also acceptable to verify identity. When using the hierarchy of approved documentation sources, the same document cannot be the source to verify both citizenship and identity.

If an individual is unable to provide any other documentary evidence of citizenship, an affidavit signed under penalty of perjury is only accepted as a last resort. Medicaid for the Elderly and People with Disabilities (MEPD) staff are required to document the reason another source is not available to verify citizenship. If Program Support Unit (PSU) staff are provided an affidavit, ensure the reason the applicant or recipient is unable to produce documentary evidence of citizenship and identity is documented on the affidavit. If the affidavit does not contain this information, the reason another source is not available is documented. PSU is responsible for transmitting the affidavit to MEPD. If the MCO is notified, the MCO staff must notify PSU via Form H2067-MC, STAR+PLUS Communication, along with a copy of the affidavit. PSU will transmit to MEPD staff on Form H1746-A, MEPD Referral Cover Sheet, along with the affidavit. The copies of the affidavit form are to be made available in all Health and Human Services Commission (HHSC) benefits offices. Form H1097, Affidavit for Citizenship/Identity, and Form H1097-S (Spanish), also may be used.1800 Member Rights and Responsibilities

Member rights and responsibilities are included in the Member Handbook. The required critical elements for member handbooks can be found at: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/.

The Member Handbook must be provided to the member at application. This document is shared in the language preference expressed by the applicant/member.

In addition, a member or their legally authorized representative may refer to the Texas Administrative Code, Title 1 Administration, Part 15 Texas Health and Human Services Commission, Chapter 353 Medicaid Managed Care, Subchapter C Member Bill of Rights and Responsibilities to view the full list of member rights and responsibilities. The Texas Administrative Code is available here: http://texreg.sos.state.tx.us/public/readtac$ext.viewtac

1900 Notifications

1910 Program Support Unit Notification Requirements

The Program Support Unit (PSU) is responsible for preparing and sending notifications to the applicant or member advising of actions taken regarding services and the right to a fair hearing. Form H2065-D, Notification of STAR Kids Managed Care Program Services, is the legal notice sent to an applicant/member of the actions taken regarding Medically Dependent Children Program (MDCP) services. The form must be completed in plain language that can be understood by the applicant/member. The language preference of the member must be considered.

The applicant or member must be notified on Form H2065-D within two business days of the date a case is certified. The form also includes information on the individual's room and board charges and copayment, if applicable.

Form H2065-D is also used to notify an applicant who is denied or a member whose services are terminated. The PSU must notify the applicant on Form H2065-D of the denial of application within two business days of the decision. See also Section 3630, Denial/Termination Procedures.

Once it is determined that a case action must be taken, Form H2065-D must be prepared and mailed to the member the same date the form is signed. Notification forms must be posted to the managed care organization's XXXSKW folder using the correct naming convention in TxMedCentral on the case action date. The PSU specialist's signature date on Form H2065-D is the case action date.

1920 MCO Notification Requirements

The managed care organization (MCO) is responsible for notifying the member when a service is either denied or reduced. This is considered an adverse action and the member has a right to appeal. Appeal rights of STAR Kids members are in the STAR Kids Managed Care Contract, which can be found at: http://www.hhsc.state.tx.us/medicaid/managed-care/contracts/star-kids-contract.pdf

1930 Notifications with MEPD Involvement

Some actions are based on decisions related to Medicaid financial eligibility determined by Medicaid for the Elderly and People with Disabilities (MEPD) staff. The Program Support Unit (PSU) must coordinate changes or the denial of waiver services with Medicaid denial decisions made by the MEPD specialist.

Although the MEPD specialist is required to notify the applicant/member of all Medicaid eligibility decisions, the PSU is required to send the Medically Dependent Children Program (MDCP) applicant/member the notification of denial of waiver services on Form H2065-D, Notification of STAR Kids Managed Care Program Services. PSU staff also send the MEPD specialist a copy of Form H2065-D at initial certification and denial for case actions that involve Medicaid eligibility.

2000 Medically Dependent Children Program Intake and Initial Application

2010 Community Services Interest List Responsibilities for Initial Requests

Individuals requesting Medically Dependent Children Program (MDCP) services must be placed on the MDCP interest list, regardless of the program's enrollment status, according to the date and time of their request. Individuals are released in order of the request date. An individual is placed on the MDCP interest list by calling the Community Services Interest List (CSIL) Unit toll-free number at 877-438-5658.

If a Health and Human Services Commission (HHSC) regional office or managed care organization (MCO) service coordinator receives a request for MDCP services, they inform the individual about the MDCP interest list and refer the individual directly to the CSIL Unit at 877-438-5658 for placement on the MDCP interest list.

The individual's name may only be added to the interest list if the individual is less than 21 years of age and resides in Texas.

2020 Community Service Interest List Unit Interest List Procedures

The Health and Human Services Commission (HHSC) Community Services Interest List (CSIL) Unit manages the following activities related to the Medically Dependent Children Program (MDCP) interest list:

- add and update individuals on the interest list;
- send an initial notification to the individual, or individual's parent or guardian, added to the interest list;
- perform annual contacts of individuals on the interest list for more than one year;
- release individuals from the interest list;
- confirm individuals in released status on the interest list are viable MDCP candidates before release by:
    - verifying the individuals address, county, and all contact information is correct;
    - if Medicaid enrolled, identifying the individual's type of assistance in the Texas Integrated Eligibility Redesign System (TIERS);
    - if the individual is enrolled in STAR Health, the individual, or individual's parent or guardian will not receive an initial contact by the CSIL Unit. The CSIL Unit forwards the release to the Program Support Interest List (PSIL) to confirm current primary medical consenter information; and
    - verifying the individual still wants to pursue MDCP services;
- provide separate lists of released individuals to the PSIL email box MDCP_Interest_List@hhsc.state.tx.us for assignment to the appropriate Program Support Unit (PSU).
    - The first list contains STAR Health members released from the MDCP interest list and the second list contains "all other" releases. When submitting the lists to the PSIL Unit, the CSIL Unit must submit each list with a separate title.
        - The title for STAR Health members released from the list must read: MDCP Interest List Releases for STAR Health Members.
        - The "all other" list for the remaining releases must read: MDCP Interest List Releases. The list of data elements for both lists will include:
            - Interest List Number;
            - Assign to PSIL date;

- Name;
- Address;
- Contact phone numbers;
- County;
- Social Security Number; and
- Medicaid Number, if applicable.

Additional instructions on MDCP interest list releases for STAR Health members is located in the STAR Health Chapter 16.2 of the Uniform Managed Care Manual (UMCM)

2030 Program Support Interest List Unit Responsibilities

The Program Support Interest List (PSIL) unit are state office staff responsible for coordinating and managing activities related to the release of an individual from the Medically Dependent Children Program (MDCP) interest list.

2031 Interest List Release and Initial Contact

Within five business days of receiving the names of interest list releases from the Community Services Interest List (CSIL) Unit, the Program Support Interest List (PSIL) must:

- create a case in the HHS Enterprise Administrative Report and Tracking System (HEART);
- check the Texas Integrated Eligibility Redesign System (TIERS) for the Medicaid type program, and document the individual's current Medicaid status and managed care organization (MCO) enrollment, if applicable, in HEART;
- contact the individual to confirm continued interest and provide a general description of the Medically Dependent Children Program (MDCP) services (See uniform managed care manual (UMCM) for specific instructions on outreach to STAR Health members);
- discuss MCOs operating in the individual's service delivery area and encourage the individual to contact the MCO for additional information and available services, if applicable;
- discuss the importance of choosing an MCO so the assessment and initial individual service plan (ISP) are completed timely and to avoid delays in eligibility determination for MDCP services;
- inform the individual the MCO in which he/she enrolls can be changed at any time after one full calendar month of MDCP service provision; and
- discuss the importance of returning the H1200, Application for Assistance - Your Texas Benefits, and other required documents, as applicable.

Within two business days of the initial contact with the individual, the PSIL must assign the HEART case to the appropriate Program Support Unit (PSU) staff to take all necessary case actions.

2032 Program Support Unit Responsibilities

The Program Support Unit (PSU) are regional Health and Human Services Commission (HHSC) staff responsible for facilitating the required components of the Medically Dependent Children Program (MDCP) eligibility process by coordinating between HHSC, managed care organizations (MCOs), and MDCP individuals.

2100 Enrollment Following Release from the Interest List

Individuals not Enrolled in Medicaid, including Individuals Enrolled in the Children Health Insurance Program (CHIP):

Within three business days of the receipt of assignment, the Program Support Unit (PSU) sends the following forms to the Medically Dependent Children Program (MDCP) individual for completion:

- Form 2602, Managed Care Organization Selection Acknowledgement, to confirm interest in applying for MDCP services;
- Form H2053-B, Health Plan Selection, and Form H2053-BS (Spanish);
- MDCP information and frequently asked questions (FAQ) information sheet;
- Form H1200, Application for Assistance – Your Texas Benefits; and
- a postage-paid envelope.

Within 14 calendar days from the date the enrollment packet is mailed to the individual, the PSU contacts the individual regarding selection of a managed care organization (MCO) as quickly as possible to ensure the selected MCO can conduct an assessment and develop the initial individual service plan. The PSU must remind the individual that a delay in selecting an MCO will result in a delay in eligibility determination for MDCP services.

Individuals Who Receive Supplemental Security Income (SSI) or SSI-Related Medicaid:

Individuals with supplemental security income (SSI) or SSI-Related Medicaid are already enrolled with a managed care organization (MCO) and receive benefits through the STAR Kids or STAR Health program. Within three business days of the receipt of assignment, the Program Support Unit (PSU) sends the following forms to the individual for completion:

- Form 2602, Managed Care Organization Selection Acknowledgement, to confirm interest in applying for Medically Dependent Children Program (MDCP) services;
- MDCP information and frequently asked questions (FAQ) information sheet; and
- a postage-paid envelope.

Individuals Who Currently Receive Other Types of Medicaid:

Individuals who receive other types of Medicaid (i.e., non-supplemental security income (SSI)) and are either served in fee-for-service or are enrolled with a STAR managed care organization (MCO) must select a STAR Kids MCO. Individuals enrolled with the STAR Health MCO will remain enrolled in STAR Health. Within three business days of the receipt of assignment, the Program Support Unit (PSU) sends the following forms to the individual for completion:

- Form 2602, Managed Care Organization Selection Acknowledgement, to confirm interest in applying for MDCP services;
- Form H2053-B, Health Plan Selection, and Form H2053-BS (Spanish);
- MDCP information and frequently asked questions (FAQ) information sheet; and
- a postage-paid envelope.

Within 14 days from the date the enrollment packet is mailed to the individual, the PSU contacts the individual regarding selection of a STAR Kids MCO so the selected MCO can conduct the assessment and develop the initial individual service plan. PSU must remind the individual that

any delay in selecting an MCO will result in a delay in eligibility determination for MDCP services.

2110 Managed Care Organization Selection

The individual has 30 days from the date of the Medically Dependent Children Program (MDCP) interest list release notification letter to complete and return enrollment materials to the Program Support Unit (PSU). An individual may be placed on multiple interest lists, but may only be enrolled in one waiver program at a time. If the individual prefers not to apply for MDCP services at the time of his or her interest list release, the individual may request to remain on the MDCP interest list, but must be notified his or her name will be placed at the bottom of the list.

If the individual has not selected a managed care organization (MCO) within 30 days of contact by the PSU, an MCO is assigned based on criteria developed by Texas Health and Human Services Commission (HHSC) from the list of available MCOs in the service area. The PSU contacts the individual within three business days of an MCO assignment, who informs him or her to inform them that:

- an MCO has been assigned to the individual; and
- the MCO in which the individual is enrolled can be changed at any time, but will not go into effect until after one full calendar month of MDCP service provision.

2120 Inability to Contact the Individual

If the Program Support Unit (PSU) staff are unable to contact the individual by phone within 14 calendar days from the date the enrollment packet was mailed to the individual, the PSU must complete and mail Form 2442, Notification of Interest List Release Closure, to the individual. Form 2442 must include the release date and release closure date, and must indicate that staff have not been able to contact the individual to begin the eligibility determination process. The release closure date is the 31st day after the date on the release notification letter.

The PSU must make one additional attempt to contact the individual prior to the release closure date.

The PSU should not attempt to contact an individual if the Health and Human Services Commission (HHSC) receives information about the individual's death. The effective date of the release closure is the date staff received information of the individual's death. PSU must not send Form 2442 to the responsible party if the release was closed due to death of the individual.

- PSU must close the release by the release closure date, if staff have not been able to contact the individual within 31 days from the date on the release notification letter.

Within three business days after closing the release, PSU must upload Form 2442 and document the closure date and reason in the HHS Enterprise Administrative Report and Tracking System (HEART).

If the individual mails the packet into PSU within 90 days of the date of the closure letter, PSU will reopen the interest list case honoring the original request date. The individual will not be placed at the bottom of the interest list, PSU will proceed with processing the information provided by the individual.

2130 Declining Medically Dependent Children Program Services

If the individual completes and mails Form 2602, Managed Care Organization Selection Acknowledgement, indicating no interest in applying for Medically Dependent Children Program (MDCP) services or declines MDCP services before the release closure date, the Program Support Unit (PSU) must close the release. The release closure date is the 31st day after the date on the release notification letter. Staff must complete and mail Form 2442, Notification of Interest List Release Closure, informing the individual the release was closed due to being informed the individual no longer wishes to apply for MDCP services. The PSU must:

- upload Form 2442 and document the closure date and reason in HHS Enterprise Administrative Report and Tracking system (HEART); and
- document the closure date and reason in the Community Services Interest List (CSIL) database.

See Uniform Managed Care Manual (UMCM) for specific requirements around denial of MDCP for STAR Health members.

2200 Receipt of Enrollment Packet

When the Program Support Unit (PSU) receives the enrollment packet back from the individual, the PSU must review to ensure all documents are completed. If all documents are not completed, the PSU must contact the individual to obtain completed forms within two business days of receipt of the incomplete information.

Unsigned applications received by Medicaid for the Elderly and People with Disabilities (MEPD) staff are returned to the individual. PSU must ensure applications are signed prior to referring to MEPD. If MEPD receives an unsigned application from PSU with Form H1746-A, MEPD Referral Cover Sheet, MEPD returns the application to PSU with an annotation on the cover form (Form H1746-A) that the application is unsigned and must be signed before the Health and Human Services Commission (HHSC) can establish a file date.

Once PSU receives notice of an unsigned application from MEPD, PSU must contact the individual within two business days, to inform of the need to return a signed application for processing.

Sending unsigned applications delays the MEPD and PSU eligibility processes and could adversely affect service delivery to the individual.

2210 Income and Resource Verifications for Medicaid Eligibility

Any information, including information on third-party insurance, obtained by the Program Support Unit (PSU) must be shared with the Medicaid for the Elderly and People with Disabilities (MEPD) specialist to prevent the individual from providing duplicate information.

Ensuring the following items are included facilitates the financial eligibility process:

- Bank accounts – bank name, account number, balance and account verification (for example, a copy of the bank statement);

- Award letters showing the amount and frequency of income payments;
- Life insurance policy – company name, policy number, face value or a copy of the policy
- Correct and up-to-date phone numbers; and
- Power of Attorney or Guardianship – copy of the legal document.

Form H1200, Application for Assistance - Your Texas Benefits, is not required for individuals receiving Supplemental Security Income (SSI) or SSI-related Medicaid, as these individuals already have Medicaid eligibility and are enrolled in STAR Kids.

Qualified Income Trust

An individual with a qualified income trust (QIT) may be determined eligible for the Medically Dependent Children Program (MDCP) even though their income is greater than the Medicaid income limit for waiver programs if they also meet all other MDCP eligibility criteria. Income diverted to the trust does not count for the purpose of financial eligibility determination, but is calculated for the determination of the co-payment for MDCP services.

Financial eligibility for an individual with a QIT is determined by Medicaid for the Elderly and People with Disabilities (MEPD) staff. MEPD staff provide information to the individual about maintaining the QIT to remain eligible for Medicaid. A trustee is designated to manage the QIT and disburse payment to service providers on behalf of the member. The individual is informed that any funds deposited into the trust must be used toward the copayment for the cost of services delivered. The MEPD specialist calculates the amount of income available from the trust for copayment and provides the amount to the Program Support Unit (PSU). The PSU notifies the managed care organization (MCO) via Form H2067-MC, Managed Care Programs Communication.

For an individual who is financially eligible based on a QIT, the eligibility based on the individual service plan (ISP) cost limit is determined before considering the use of funds from the trust for the purchase of services. Funds from the trust determined to be available for copayment are used to purchase waiver services for the individual but are not used to reduce the cost of the ISP until after eligibility is determined to avoid the possibility of "purchase" of waiver eligibility. The MCO must ensure the individual meets the initial ISP cost limit requirement before deducting the co-payment. If the MCO does not properly establish this plan of care and the Member's cost exceeds the individual limit, the MCO must continue to provide MDCP services to the Member at the MCO's expense. The MCO may not terminate MDCP services if a Member exceeds his or her cost limit.

First, the ISP is developed by the MCO without consideration of the trust. Then, if the individual is eligible for MDCP within the cost limit, the co-payment is allocated to purchase MDCP services identified on Form 2604, STAR Kids Individual Service Plan. The ISP total and the amount of the provider's service authorizations are reduced by the amount of the co-payment. The member must pay the provider(s) directly for the amount of services. The MCO must document the QIT in the ISP. Continuing Medicaid eligibility through the MDCP waiver is contingent upon copayment to the provider(s).

Refer to Qualified Income Trust Copayment for specific PSU and MCO procedures related to QIT copayments.

Non-Medicaid Individuals or Individuals Enrolled in the Children Health Insurance Program:

Within two business days of receiving the enrollment packet or confirmed interest from the individual, PSU must:

- upload enrollment packet documents into HEART; and
- complete Section A of H3676, Managed Care Pre-Enrollment Assessment Authorization, and upload to TxMedCentral.

The PSU must submit the following to the MEPD within two business days following the date of receipt of Form H1200, Application for Assistance - Your Texas Benefits:

- Form H1200; and
- Form H1746-A, MEPD Referral Cover Sheet, identifying the action to be taken.

PSU must upload the enrollment documents into the HHS Enterprise Administrative Report and Tracking System (HEART). The PSU must retain the original Form H1200 with the individual's valid signature in the HEART electronic case file.

The PSU requests financial eligibility determination for the MDCP on Form H1746-A.All available verification documents provided by the individual must be attached. The PSU keeps a copy of all documents and records the date the application was faxed or mailed in the HEART electronic case file.

The PSU must follow procedures in Section 2400, Money Follows the Person Option, regarding Medicaid eligibility for individuals transitioning from a nursing facility to the community.

Individuals Currently Enrolled in STAR Kids
An individual meets the Medicaid eligibility requirement for MDCP if the individual receives Supplemental Security Income (SSI) or SSI-Related Medicaid.

Within two business days of receiving the enrollment packet or confirmed interest from the individual, Program Support Unit (PSU) must:

- verify the individual receives SSI or SSI-Related Medicaid in Texas Integrated Eligibility Redesign System (TIERS);
- verify the STAR Kids enrollment in TIERS;
- upload enrollment packet documents into HHS Enterprise Administrative Report and Tracking System (HEART); and
- complete Section A of H3676, Managed Care Pre-Enrollment Assessment Authorization, and upload to TxMedCentral. For TP45, newborn children up to age one, born to Medicaid-eligible mothers, if the individual does not have an established social security number, PSU will be required to indicate all zeros in item #3, social security number in Section A of Form H3676.

Individuals Currently Receiving Other Types of Medicaid:

Within **two business days** of receiving the enrollment packet or confirmed interest from the individual, PSU must:

- upload enrollment packet documents into HHS Enterprise Administrative Report and Tracking System (HEART); and

- complete Section A - Referral/Assessment Authorization of H3676, and upload to TxMedCentral.

2220 Managed Care Organization Coordination

The STAR Kids managed care organization (MCO) has 30 calendar days to complete all assessments for individuals enrolled in Medically Dependent Children Program (MDCP) and submit required forms to the Program Support Unit (PSU). The MCO has an additional 30 days to submit all required documentation, for a total of 60 days following the initial notice from PSU. The MCO:

- verifies the individual meets all other eligibility criteria referenced in Section 1000;
- completes Section B of Form H3676, Managed Care Pre-Enrollment Assessment Authorization;
- completes the STAR Kids Screening and Assessment Instrument (SK-SAI) tool, including Section R - MDCP Related Items; and
- completes Form 2604, STAR Kids Individual Service Plan .

The MCO must schedule and complete the SK-SAI, including the MDCP module, within 30 business days of notice from PSU. Once the SK-SAI and MDCP Module are complete, the MCO must submit the results from the SK-SAI to the Texas Health and Human Services Commission (HHSC) Administrative Services Contractor, Texas Medicaid & Healthcare Partnership (TMHP), within 72 hours of completion. For the purposes of this requirement, an SK-SAI is considered "complete" when the MCO has obtained the physician's signature using Form 2601, Physician Certification, and has retained this form in the individual's case file.

A determination of medical necessity must be based on information collected as part of the SK-SAI and MDCP Module. A medical necessity (MN) determination must be authorized through HHSC or its designee.

TMHP processes SK-SAI for individuals to determine MN and calculate a Resource Utilization Group (RUG). A RUG is a measure of nursing facility staffing intensity and is used in waiver programs to:

- categorize needs for individuals/members; and
- establish the service plan cost limit.

When TMHP processes an SK-SAI, the MCO will receive a substantive response file with a three-alphanumeric digit RUG. This code may also be viewed in the TMHP Long Term Care (LTC) online portal. An SK-SAI with incomplete information will result with a BC1 code instead of a RUG value. An SK-SAI resulting with a BC1 code does not have all of the information necessary for TMHP to accurately calculate a RUG for the individual/member. Code BC1 is not a valid RUG to determine MDCP eligibility.

The MCO must correct the information on the SK-SAI within 14 calendar days of submitting the assessment that resulted in a BC1 code. After 14 calendar days, the MCO must inactivate the SK-SAI and resubmit the assessment with correct information to TMHP. Information about the process of transmitting and correcting an SK-SAI is available in Appendix I- STAR Kids Individual Service Plan - Narrative Form.

The MDCP Module of the SK-SAI establishes an annual cost limit for each individual/member receiving MDCP services, which is based on the anticipated cost if the individual/member received services in a nursing facility.

As a part of the individual service plan (ISP) planning process, the MCO must establish an MDCP ISP that does not exceed the individual's cost limit. If the MCO does not properly establish this plan of care and the individual's/member's ISP cost exceeds the individual limit, the MCO must continue to provide MDCP services at the MCO's expense.

The MCO may not terminate MDCP enrollment if an individual's/member's ISP exceeds the cost limit. The MCO must also adopt a methodology to track each member's MDCP-related expenditures on a monthly basis and provide an update on MDCP-related expenditures to the member and/or the member's legally authorized representative no less than once per month.

Service authorizations for MDCP must include the amount, frequency, and duration of each service to be provided, and the schedule for when services will be rendered. The MCO must ensure the MDCP member does not experience gaps in authorizations and that authorizations are consistent with information in the member's ISP.
The MDCP STAR Kids Member's ISP must include the components of a person-centered service plan described in Title 42 of the Code of Federal Regulations §441.301(c)(2).

The MCO posts the MDCP ISP to TxMedCentral in the MCO's STAR Kids folder, following the naming instructions in Appendix VIII. The MCO posts Form H3676 to TxMedCentral in the MCO's STAR Kids folder, following instructions in Appendix VIII. If the MCO does not post an ISP within 60 calendar days after the PSU posted Form H3676, Part A, the PSU notifies by email the health plan manager assigned to the MCO.

2230 Program Support Unit Coordination for Individuals Enrolling in the Medically Dependent Children Program

Within two business days of receiving the Form H3676, Managed Care Pre-Enrollment Assessment Authorization and Form 2604, Individual Service Plan, the Program Support Unit (PSU) ensures the individual has:

- medical necessity;
- financial eligibility;
- services under the established cost limits; and
- an unmet need for at least one waiver service.

For individuals needing a Medicaid eligibility financial decision, PSU must notify the Medicaid for the Elderly and People with Disabilities (MEPD) specialist that the individual meets medical necessity. This notification must be documented on Form H1746-A, MEPD Referral Cover Sheet, and emailed to the MEPD specialist. The MEPD specialist may view the Texas Integrated Eligibility Redesign System (TIERS) or Long Term Care (LTC) online portal to confirm the individual meets the medical necessity criteria. The start of care (SOC) date for Medically Dependent Children Program (MDCP) services is the first day of the month following receipt of the latter of:

- STAR Kids Screening Assessment Instrument (SK-SAI);
- Individual Service Plan (ISP); and
- Medicaid eligibility.

For example, the SOC date is the same as the individual service plan (ISP) begin date, and will always be the first day of the month. Because individuals are not eligible for any MDCP benefits between the Form H2065-D signature date and the ISP begin date, PSU specialists must record the correct date on the notification to the member.

If eligibility is approved, within two business days of receiving the Form H3676 and Form 2604, Individual Service Plan, PSU generates Form H2065-DSK, and:

- mails the original to the individual;
- posts the form on TxMedCentral in the managed care organization's (MCO's) STAR Kids folder, following the instructions in Appendix IX, Naming Conventions;
- emails a copy to MEPD staff;
- notifies Enrollment Resolution Services (ERS) by emailing HPO_Star_Plus@hhsc.state.tx.us; and
- documents the closure date and reason in the Community Services Interest List (CSIL) database.

PSU must upload all applicable case forms to the HHS Enterprise Administrative Report and Tracking System (HEART).

2240 Program Support Unit Coordination for Eligibility Denial

If the individual fails to meet eligibility criteria for Medically Dependent Children Program (MDCP) or Medicaid is denied by the Medicaid for the Elderly and Persons with Disabilities (MEPD) unit for financial eligibility, within two business days of receiving the Form H3676, Managed Care Pre-Enrollment Assessment Authorization and Form 2604, Individual Service Plan, Program Support Unit (PSU) completes Form H2065-DSK, Notification of STAR Kids Program Services, and:

- mails the original to the individual;
- posts it on TxMedCentral in the managed care organization's (MCO's) MDCP folder, following the instructions in Appendix IX, Naming Conventions;
- emails a copy to MEPD staff; and
- documents the closure date and reason in the Community Services Interest List (CSIL) database.

PSU must upload all applicable case forms to the HHS Enterprise Administrative Report and Tracking System (HEART).

2300 Interest List Release Closures

The Program Support Unit (PSU) must change the status of an interest list release in the Community Services Interest List (CSIL) database.

PSU will record the appropriate closure code in CSIL when an individual cannot complete the application process or when the individual receives a Medically Dependent Children Program (MDCP) determination. Interest list closures are documented in the Texas Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART).

Closing the Interest Release for an Individual Choosing Community Living Assistance and Support Services

When an individual is offered both Medically Dependent Children Program (MDCP) and Community Living Assistance and Support Services (CLASS) and the individual chooses CLASS, Program Support Unit (PSU) must notify the Program Support Interest List (PSIL) to close the MDCP release effective the date the PSU is notified of the decision to apply for

CLASS. PSU notifies the PSIL Unit by emailing the designated box MDCP_Interest_List@hhsc.state.tx.us. The email's subject line must read: MDCP Closure. The following elements must be included in the email:

- Individual's name;
- Interest List ID;
- Program to be closed;
- Date of closure; and
- Closure Reason.

Within two business days of receiving notification of the individual's choice to apply for CLASS, Form 2442, Notification of Interest List Release Closure, PSU must mail to the CLASS individual. A copy of Form 2442 must be recorded in the individual's electronic case file in Texas Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART). Once Form 2442 is sent to the CLASS individual, no follow-up contacts with the individual/family are necessary.

If the CLASS application is denied, Form 2442 instructs the individual to contact Texas Health and Human Services Commission (HHSC) if he/she wishes to apply for Medically Dependent Children Program (MDCP). When the individual contacts HHSC, he/she will be reinstated on the MDCP interest list using the procedures in Section 2310, Contacting the Program Support Interest List (PSIL) Unit to Reopen an Interest List Closure in the Community Services Interest List (CSIL) database.

2310 Contacting Program Support Interest List Unit to Reopen an Interest List Closure

The Program Support Unit (PSU) must submit a request to the Program Support Interest List (PSIL) Unit to reopen an individual's closed interest list record for the following reasons:

- PSU staff were not able to contact the individual before the release closure date.
- The individual received a dual offer (an offer to select one of two waiver slots), did not meet eligibility for the alternate waiver program and wishes to apply for Medically Dependent Children Program (MDCP) services.

Within three business days of receiving the request to apply for MDCP services, PSU staff must email a completed Form H2067-MC, Managed Care Programs Communication, to the PSIL designated box and must include:

- the release date;
- the release closure date;
- the reason for the closure; and
    - the reason for requesting to reopen an individual's closed CSIL record; or
    - a statement indicating that the application for an alternate waiver program was denied and the individual now wishes to apply for MDCP.

The PSIL Unit will notify PSU of the outcome of the request. If an exception is granted, the PSU must contact the individual to begin the application process.

2320 Adding a Name Back to the Interest List

An individual's name may be added back to the Community Services Interest List (CSIL) when the name has been removed because staff are unable to locate or the individual's failure to respond to attempted contacts. A name is added back if the individual:

- contacts the Program Support Interest List Unit (PSIL) within 90 calendar days of the closure date and expresses continued interest, the name will be added back with the **original date** of request; or
- contacts the Program Support Unit (PSU) more than 90 calendar days following the closure date and expresses continued interest, the name will be added back with the **current date** as the request date.

Any exceptions for adding names back to the CSIL with the original date after a 90 day period must be approved by the Texas Health and Human Services Commission (HHSC) Program Enrollment manager.

2321 Earliest Date for Adding an Individual Back to the Interest List after Denial

The earliest date an individual may be added back to the Community Services Interest List (CSIL), for the same program the individual is denied, is the date the individual is determined to be ineligible for the program.

Example: The individual is released from the Medically Dependent Children Program (MDCP) interest list on Aug. 2. The individual is denied eligibility for MDCP on Aug. 28, and a notification is sent to the individual of ineligibility. The first date the denied individual can be added back to the MDCP interest list is Aug. 28.

The earliest date an individual may be added back to the CSIL for the same program the individual is terminated is the first date the individual is no longer eligible for the program terminated.

Example: An individual's MDCP services are terminated July 31st due to denial of medical necessity. The first date the individual can be added back to the MDCP interest list is Aug. 1.

2400 Money Follows the Person

2410 Traditional Money Follows the Person

Reserved

2420 Money Follows the Person Limited Nursing Facility Stay for Medically Fragile Individuals

The limited nursing facility (NF) stay process applies to individuals who request Medically Dependent Children Program (MDCP) services through Money Follows the Person (MFP) option, but are too medically fragile to reside in a NF for an extended period of time, and request to complete a limited NF stay. Individuals are either already enrolled in STAR Kids or new to the

program. Medically fragile is defined as a chronic physical condition that results in a prolonged dependency on medical care.

The Health and Human Services Commission (HHSC) nurse will review the medical fragility criteria and physician's attestation documented on the Form 2406, Physician Recommendation for Length of Stay in a Nursing Facility, for an individual requesting a limited NF stay. Medical judgment of the HHSC physician will be applied when the individual's physician does not check two or more of the below criteria and the individual's physician's attestation is "too medically fragile and cannot reside in a NF setting for an extended period of time without impact to his/her health and safety" on Form 2406. Typically, an individual must meet two or more of the following criteria to be considered medically fragile:

- Ventilator dependent (not Bi-level Positive Airway Pressure (BiPap));
- Renal dialysis;
- 24 hour/day oxygen dependence;
- Total nutrition via enteral tube feeding;
- Total parenteral nutrition (TPN);
- Tracheostomy;
- Seizures requiring medical intervention (e.g., medication administration, oxygen) during the seizure, every day for the past six months;
- Documented immune deficiency confirmed by lab findings (i.e., IgA or IgG deficiency) or on immunosuppressive drug therapy;
- Congestive heart failure requiring hospitalization within the past six months; or
- Hospice.

Individuals determined medically fragile by the HHSC nurse or physician and approved for a limited NF stay must stay at least part of two days in the NF. Admission and discharge from the facility must be on different days. MDCP services must be authorized within 24 hours of discharge to allow for continuity of services (and establish Medicaid in an NF).

2420.1 Money Follows the Person Procedures for Requesting a Limited Nursing Facility Stay

Individuals requesting Medically Dependent Children Program (MDCP) services through the limited nursing facility stay Money Follows the Person (MFP) option may contact the Community Services Interest List (CSIL) Unit at 877-438-5658, a Texas Health and Human Services Commission (HHSC) regional office, or his or her managed care organization (MCO) service coordinator. If an individual contacts an HHSC regional office, or his or her MCO service coordinator, the HHSC regional office or MCO service coordinator will refer the individual to the CSIL Unit to add the individual's name to the interest list. This request will not be considered a release from the interest list, but a referral of an individual interested in by-passing the interest list through the MFP option.

The CSIL Unit must explain the following to the individual requesting to by-pass the MDCP interest list:

  - STAR Kids program, if not enrolled;
  - an overview of MDCP services;

the limited stay enrollment process, including an explanation to the individual on completing a limited nursing facility stay if the individual is determined to be too medically fragile to complete an extended nursing facility stay which must first be approved;

- a facility may charge individuals a fee for the stay, which Medicaid will not reimburse;
- Form 2406, Physician Recommendation for Length of Stay in a Nursing Facility, regarding the physician's recommendation for the length of stay the individual can safely complete in a nursing facility;
- required medical documentation within 12 months of the date the documentation is being submitted; and
- admission and discharge documentation from the nursing facility.

The CSIL Unit informs the individual, or the individual's parent or guardian, that the individual's physician must complete Form 2406, Physician Recommendation for Length of Stay in a Nursing Facility, with supporting documentation and return to the CSIL Unit within 30 calendar days of the initial contact with the individual, or the individual's parent or guardian. The CSIL Unit will send Form 2406 to the individual, or individual's parent or guardian within one calendar day of the contact along with a self-addressed stamped envelope to the individual to return back to the CSIL Unit.

If the individual, or individual's parent or guardian, is reapplying after being denied the limited stay in the past, the CSIL Unit must inform the individual, parent or guardian a new Form 2406 must be completed and a new copy of medical records obtained. Previous medical documentation will not be considered.

2420.2 Community Services Interest List Unit Receipt of Form 2406

Attachments to Form 2406

Form 2406, Physician Recommendation for Length of Stay in a Nursing Facility, must be completed by an individual's physician to be considered for a limited nursing facility (NF) stay. The physician must attach documentation (such as a visit note or hospital discharge summary) of chronic conditions to Form 2406. The medical documentation provided must:

- document the individual's chronic conditions, the current health status of the individual and substantiate the boxes checked on the form; and
- be within 12 months of the date the documentation is submitted

Note: Medical documentation over 12 months old will not be considered in the limited stay determination. If all the medical documentation submitted is over 12 months old, the request is incomplete. The Community Services Interest List (CSIL) Unit must contact the individual, parent or guardian within 3 calendar days of receipt, to inform them of the requirement that medical documentation must be within 12 months of the date being submitted. The CSIL Unit documents delays in obtaining medical documentation, and conversations with the individual regarding the money follows the person (MFP) Limited Stay option.

Upon receipt of Form 2406 and the medical documentation, the CSIL Unit identifies the physician's recommendation. If the physician attests that the patient does not meet the

medically fragile criteria for a limited nursing facility stay, within two calendar days of receipt of Form 2406, the CSIL Unit must:

- contact the individual by phone to inform him of the physician's recommendation, and of the option to transition from a nursing facility as described in Section 2410, Traditional Money Follows the Person, Individuals Currently Residing in a NF, to access Medically Dependent Children's Program (MDCP) through the MFP option. If the individual does not choose to transition from a nursing facility as described in Section 2130, their name will remain on the interest list.

If the individual, or the individual's parent or guardian, decides not to pursue services through the MFP Limited Stay option and requests to access services through the traditional MFP option, refer to procedures outlined in Section 2410, Traditional Money Follows the Person.

If the individual's physician attests that the patient does meet the medically fragile criteria or is too medically fragile and cannot reside in a nursing facility setting for an extended period of time without impact to his/her health and safety on Form 2406 within two calendar days, the CSIL Unit will verify:

- the form is completed in its entirety; and
- the individual's name printed on the form is legible and the physician's name, address, license number, signature, and date are on the form.

If Form 2406 does not contain the required information, the CSIL Unit contacts the individual, or the individual's parent or guardian, within two calendar days of receipt of the notice to discuss the elements of the form that are incomplete. The CSIL Unit informs the individual, or the individual's parent or guardian that the form is being returned for completion by the individual's physician, and must be returned to the CSIL Unit within 30 calendar days of contact. The CSIL Unit returns Form 2406 to the individual, or the individual's parent or guardian, within two calendar days of contact with the individual, or the individual's parent or guardian. If Form 2406 has not been returned by the 30th day, the CSIL Unit:

- calls the individual to notify him that his request to access MDCP services through the MFP option is closed.

If Form 2406 does contain all required information, the CSIL Unit will forward Form 2406 along with the completed legible medical records required for the limited stay packet to the PSIL. The limited stay packet includes:

Program Support Interest List Receipt of Limited Stay Referral and Processing

Upon receipt of the limited stay referral, the Program Support Interest List (PSIL) Unit will:

- create a case in the Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART) documenting the date of the individual's Money Follows the Person (MFP) limited stay request;
- inform the Texas Health and Human Services Commission (HHSC) nurse via HEART assignment of the need to access Form 2406 and medical documentation for review.

- check the Texas Integrated Eligibility Redesign System (TIERS) for the Medicaid type program and managed care organization (MCO) enrollment;
- if the individual is enrolled in STAR Kids, notify the member's MCO the member is requesting to access Medically Dependent Children Program (MDCP) through the limited stay process by posting Form H2067-MC, STAR+PLUS Managed Care Programs Communication, to the member's STAR Kids folder in TxMedCentral; and
- upload a copy of the Form H2067-MC in HEART.

The PSIL must submit Form 2406 to the HHSC nurse within three calendar days of receipt to determine if the individual meets the medically fragile criteria.

2420.3 Texas Health and Human Services Nurse Determination

A Health and Human Services Commission (HHSC) nurse will review Form 2406, Physician Recommendation for Length of Stay in a Nursing Facility and medical documentation within two calendar days, to determine if an individual meets the limited stay criteria.

If the individual's physician attests they meet the medically fragile criteria, the HHSC nurse may approve the limited stay request if the physician's documentation clearly substantiates the individual meets two or more criteria on Form 2406. Within two calendar days of the decision, the HHSC nurse will document the determination status in HHS Enterprise Administrative Report and Tracking System (HEART) and notify the Program Support Interest List (PSIL) Unit via an appointment notice of the need to check HEART for further action.

If the documentation does not substantiate the individual meets two or more criteria on Form 2406, the HHSC nurse will document the decision to "submit to the HHSC Physician" in the HEART case and follow procedures in Section 2420.4, Submission of Form 2406 to the HHSC Physician.

2420.4 Submission of Form 2406 to the Texas Health and Human Services Physician

The Health and Human Services Commission (HHSC) nurse emails Form 2406, Physician Recommendation for Length of Stay in a Nursing Facility, and all medical documents dated within the past 12 months to the HHSC physician for review within two calendar days of the decision. The Program Support Interest List (PSIL) Unit that received the Form 2406 must be included in the email.

When submitting Form 2406 to the HHSC physician, the HHSC nurse must submit each request in a separate email. The email's subject line must read: Medically Dependent Children Program (MDCP) Form 2406 for XX. The "XX" in the title represents the initials of the individual; therefore, the subject line of an email on behalf of Ann Smith would read "MDCP Form 2406 for AS."

2420.5 HHSC Physician Determination of Medical Fragility

The Health and Human Services Commission (HHSC) physician will determine if the individual meets the medically fragile criteria. The HHSC physician will respond via email to the HHSC nurse and the Program Support Interest List (PSIL) Unit. The response will be either meets

criteria or does not meet criteria. The PSIL Unit contacts the individual, or the individual's parent or guardian, by phone within two calendar days of receipt of the HHSC physician email to advise the individual of the outcome of the limited stay request. If the physician has a comment regarding the information submitted, this will be noted in the physician response to the PSIL Unit. The PSIL Unit must include this comment when advising the applicant of the outcome of the limited stay request.

If the limited nursing facility stay is approved, or the individual chooses to transition from a nursing facility as described in Section 2410, Traditional Money Follows the Person, within two calendar days of being notified of the individual's choice, the PSIL Unit will place the individual in an Medically Dependent Children Program (MDCP) assigned status by using the bypass code "Residing in a Nursing Facility" in the Community Services Interest List (CSIL) database.

If the HHSC physician determines the individual does not meet the medically fragile criteria, the PSIL Unit contacts the individual, or the individual's parent or guardian, by phone within two calendar days of receipt of the physician's email. The PSIL Unit will inform the individual that a limited nursing facility (NF) stay is not approved, and the individual has the option to transition from a NF stay as described in Section 2410 to access MDCP through the Money Follows the Person (MFP) option. If the individual does not choose to complete a NF stay as described in that section, his or her name will remain on the interest list. The PSIL should explain the individual may re-apply in the future by contacting the CSIL Unit as described in Section 2420, Money Follows the Person Procedures for Requesting a Limited Nursing Facility Stay, to begin the process again. Once a determination has been rendered by the HHSC physician, additional information regarding an individual's condition will not be considered as part of the original request.

The PSIL Unit will:

- if the individual is a member of STAR Kids, inform the member's managed care organization (MCO) that he or she has not been approved for a limited stay by posting Form 2067-MC in the MCO's STAR Kids folder in TxMedCentral;
- uploads a copy of Form H2067-MC and immediately close HHS Enterprise Administrative Report and Tracking System (HEART); and
- remove the "Residing in a Nursing Facility" bypass code and place the individual's name in open status.

2420.5.1 Program Support Interest List Procedures for Assigning Individuals Approved for a Limited Nursing Facility Stay to Program Service Unit Regional Staff

Within two calendar days of an individual approved for a limited nursing facility (NF) stay as outlined in Section 3520.5, Program Support Interest List Unit must assign the HHS Enterprise Administrative Report and Tracking System (HEART) case to the appropriate Program Support Unit (PSU) staff to take all necessary case actions.

2420.6 Program Support Unit Procedures for Individuals Who Are Approved for a Limited Nursing Facility Stay and Currently Enrolled in STAR Kids

When an individual enrolled in STAR Kids is approved for a limited nursing facility (NF) stay as outlined in Section 3520.5, within five calendar days of case assignment, the Program Support Unit (PSU) staff must:

- complete Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization, and post it on TxMedCentral in the Managed Care Organization's (MCO) STAR Kids folder; and
- ensure understanding the limited stay must be coordinated with his or her MCO service coordinator and cannot be completed until notified by his or her service coordinator.

2420.6.1 Program Support Unit Procedures for Individuals Who Are Approved for a Limited Nursing Facility Stay and Not Enrolled in Medicaid (including Individuals Enrolled in Children's Health Insurance Program)

When an individual who is not enrolled in STAR Kids is approved for a limited nursing facility stay as outlined in 2420.1 Money Follows the Person Procedures for Requesting a Limited Nursing Facility Stay, within five calendar days of case assignment, the Program Support Unit (PSU) takes the following steps to ensure the individual is successfully enrolled in STAR Kids and Medically Dependent Children Program (MDCP).

PSU staff contact the applicant or the applicant's parent or guardian to:

- explain the Medicaid application process;
- discuss a list of managed care organizations (MCOs) and encourage the applicant to contact one for service information;
- discuss the importance of choosing an MCO so assessments and initial individual service plans (ISPs) can be completed timely in order to avoid a delay in eligibility determination for MDCP services;
- inform the applicant the MCO in which he or she enrolls can be changed at any time after the first month of service; and
- ensure understanding the limited stay must be coordinated with his or her MCO service coordinator and cannot be completed until notified by his or her service coordinator.

The PSU sends the following forms to the applicant for completion:

- Form H1200, Application for Assistance – Your Texas Benefits;
- Form H3034, Disability Determination Socio-Economic Report; and
- Form H3035, Medical Information Release/Disability Determination;
- Form H2053-B, Health Plan Selection, and Form H2053-BS (Spanish);
- Form 0003, Authorization to Furnish Information; and
- a postage-paid envelope.

Once the forms are returned to the PSU, the PSU uploads the forms to HEART. The PSU sends the signed and completed application forms, including all medical documentation previously submitted with Form 2406, within two calendar days of receipt to Medicaid for the Elderly and People with Disabilities (MEPD) staff, along with Form H1746-A, MEPD Referral Cover Sheet, identifying the action to be taken. The PSU must also notify MEPD by sending an email to OESMEPDIC@hhsc.state.tx.us, when sending the Form H1200 to ensure the application is assigned immediately. The email's subject line must read: MDCP Request for Expedited Processing for XX. The "XX" in the title represents the initials of the individual; therefore, the subject line of an email on behalf of Ann Smith would read "MDCP Request for Expedited Processing for AS". These assignments will be special assigned by an MEPD complaint

resolution staff, to the region in which the individual resides in, requesting the processing be expedited. MEPD will notify the PSU using the MEPD to DADS/PSU Communication when the Medicaid application has been approved pending the limited stay and 30 days of MDCP service via Form H1746-A.

The individual chooses an MCO and notifies PSU verbally or in writing using Form H2053-B, Health Plan Selection.

Within two calendar days of the MCO selection, PSU completes Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization, and posts it on TxMedCentral in the MCO's STAR Kids folder.

2420.6.2 Program Support Unit Procedures for Individuals Who Are Approved for a Limited Nursing Facility Stay with Medicaid and Not Enrolled in STAR Kids

When an individual with Medicaid eligibility, but who is not enrolled in STAR Kids, is approved for a limited nursing facility (NF) stay as outlined in 2420.1 Money Follows the Person Procedures for Requesting a Limited Nursing Facility Stay, within five calendar days of case assignment, the Program Support Unit (PSU) takes the following steps to ensure the individual is successfully enrolled in STAR Kids and Medically Dependent Children Program (MDCP).

PSU staff contact the applicant or the applicant's parent or guardian to:

- explain the application process;
- discuss a list of managed care organizations (MCOs) and encourage the individual to contact one for service information;
- discuss the importance of choosing an MCO so assessments and initial individual service plans (ISPs) can be completed timely in order to avoid a delay in eligibility determination for MDCP services;
- inform the individual the MCO in which he or she enrolls can be changed at any time after the first month of service; and
- ensure understanding the limited stay must be coordinated with his or her MCO service coordinator and cannot be completed until notified by his or her service coordinator.

PSU sends the following form to the applicant for completion:

- Form H2053-B, Health Plan Selection, and Form H2053-BS (Spanish); and
- a postage-paid envelope.

The individual chooses an MCO and notifies PSU verbally or in writing using Form H2053-B, Health Plan Selection.

Within two calendar days of the MCO selection, PSU completes Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization, and posts it on TxMedCentral in the MCO's STAR Kids folder.

2420.6.3 Program Support Unit and Managed Care Organization Coordination Procedures for Medically Dependent Children Program Applicants Approved for a Limited Nursing Facility Stay

When an individual is approved for a limited nursing facility (NF) stay, the managed care organization (MCO) service coordinator must contact the individual, or the individual's parent or guardian, within 14 calendar days from the date they receive the Form H3676, Managed Care Pre-Enrollment Assessment Authorization, informing them of the decision to complete a limited nursing facility stay. The STAR Kids Managed Care Contract requires the MCO to initiate contact with an applicant to begin the assessment process within 14 calendar days of receipt of Form H3676. At the contact, the MCO informs the individual, or the individual's parent or guardian, of the Medically Dependent Children Program (MDCP) eligibility process. The MCO explains the overnight limited stay, and that they must present Form 3618, Resident Transaction Notice, to the MCO service coordinator showing the time and date of the limited stay admission and discharge before MDCP services can be authorized. The MCO must explain the individual must not proceed with the limited stay until they are authorized to do so. MDCP services must be authorized within 24 hours of the nursing facility discharge date to meet Money Follows the Person (MFP) funding requirements.

The MCO has 60 calendar days to complete all assessments and submit required forms to the PSU. The MCO completes:

- Section B of Form H3676, noting "MFP Limited Stay" in the comments section;
- the STAR Kids Screening and Assessment Instrument (SAI), including Section R - MDCP Related Items;
- the electronic individual service plan (ISP) and
- Form 2603, Individual Service Plan - Narrative.

The MCO posts the Form H3676 to TxMedCentral in the MCO's ISP folder and submits the electronic ISP via the X12 278 transaction. The MCO maintains a copy of the narrative ISP in the member or applicant's case file.

If the MCO does not submit an ISP within 60 calendar days after the PSU posted Form H3676, Part A, the PSU notifies by email the health plan manager (HPM) assigned to the MCO.

Within two calendar days of receiving the Form H3676 and Form 2603, the PSU ensures the member has:

- medical necessity (MN);
- ongoing financial eligibility or Form H1746-A from MEPD stating Medicaid is approved pending the limited stay and 30 days of MDCP services;
- services under the established cost limits; and
- an unmet need for at least one waiver service.

For STAR Kids members accessing MDCP through the limited stay process, if the above criteria are met, except for the limited stay, PSU posts Form H2067-MC, Managed Care Programs Communication, to the MCO's ISP folder, notifying them of the approval pending completion of the limited stay.

For applicants not receiving Medicaid, and since Medicaid will not be established until 30 days after the applicant completes the limited stay, the PSU can approve the individual to move forward to complete the limited stay as long as all other eligibility criteria are met. The PSU posts Form H2067-MC in the MCO's ISP folder, notifying the MCO to proceed with the limited stay.

The MCO service coordinator must coordinate the limited stay in the nursing facility (NF) with the MDCP applicant or his or her parent or guardian and the PSU to ensure the PSU staff is available to determine eligibility and for the MCO service coordinator to authorize MDCP services within 24 hours after discharge. Form 3618 must be completed by the NF and submitted to the MCO service coordinator within 24 hours of the time of discharge. Service coordinators must stress that in order to ensure compliance with MFP policy for continuity of services, an applicant may not discharge, under the limited stay process, from an NF on a Friday, Saturday, Sunday, or any day preceding or the day of a state holiday and that services must be authorized within 24 hours of discharge. If MDCP services cannot be authorized within 24 hours after the NF discharge date, the NF stay will not be accepted as meeting MFP policy.

Once the date of the limited stay is known, but prior to it occurring, the MCO service coordinator informs the assigned PSU staff of the limited stay date by posting Form H2067-MC to TxMedCentral in the MCOs STAR Kids folder.

Within 24 hours of the limited stay, the following activities occur:

- The MCO must notify PSU that the limited stay occurred on Form H2067-MC requesting PSU approve MDCP services and post the form to TxMedCentral in the MCO's ISP folder.
- The MCO must post Form 3618 to TxMedCentral in the MCOs STAR Kids folder.
- The PSU must respond to the MCO on Form H2067-MC by posting to TxMedCentral in the MCOs STAR Kids folder that the applicant or member is pending approval of Medicaid eligibility; however, the member is eligible for MDCP services and the MCO must send an authorization to the selected provider to begin services.

Once the individual is receiving MDCP services, the service coordinator notifies the PSU by posting Form H2067-MC to TxMedCentral in the MCO's ISP folder:

Once the MCO notifies the PSU the member is authorized to receive MDCP services, within two calendar days, the PSU:

- Notifies the PSIL Unit by emailing the MDCP_Interest_List@hhsc.state.tx.us requesting MDCP interest list closure and documenting the reason; and
- Notifies MEPD, via Form H1746-A, MEPD Referral Cover Sheet that the member has transferred from a NF to the MDCP waiver, if applicable.
- Completes Form H2065-D, and:
    - mails the original to the member;
    - posts the form on TxMedCentral in the MCO's STAR Kids folder;
    - emails a copy to MEPD staff, if applicable; and

- notifies Enrollment Resolution Services (ERS) by emailing HPO_Star_Plus@hhsc.state.tx.us, if applicable.

If eligibility is denied, within two calendar days of determining applicant or member does not meet MDCP eligibility, the PSU completes Form H2065-D, and:

- notifies the PSIL Unit by emailing the MDCP_Interest_List@hhsc.state.tx.us stating that the applicant or member was denied and the reason for the denial;
- mails the original to the applicant or member;
- posts it on TxMedCentral in the MCO's STAR Kids folder, following the instructions in Section XXXX, TxMedCentral Naming Convention and File Maintenance; and
- emails a copy to MEPD staff, if applicable.

PSU must upload all applicable case forms to HHS Enterprise Administrative Record Tracking System (HEART).

PSU data entries within five calendar days of receipt of all required eligibility verification.

After the individual has been determined eligible for MDCP, ERS updates the member's TIERS record to indicate managed care enrollment, if applicable.

2420.8 Delays in Limited Nursing Facility Stay for Applicants Not Enrolled in STAR Kids

If there is delay in the nursing facility (NF) stay, the managed care organization (MCO) must notify the Program Support Unit (PSU) by posting form H2067-MC, Managed Care Programs Communication, to TxMedCentral in the MCOs STAR Kids folder.

If the NF stay cannot be completed within 40 days after the date Form H1200, Application for Assistance-Your Texas Benefits, was submitted to Medicaid for the Elderly and People with Disabilities (MEPD), the PSU must request that MEPD delay certification. The PSU documents the request for a delay in certification on Form H1746-A, MEPD Referral Cover Sheet, submits the forms to MEPD, and uploads the form to HHS Enterprise Administrative Report and Tracking System (HEART). The PSU should include the following statement in the comments section of Form H1746-A: “Request for delay in certification due to delay in NF stay; start date of waiver services is pending.” The delay request, if approved, will extend the MEPD time frame to 135 days from the original file date or 180 days from the original file date if a disability determination is required. If there is a continued delay in completion of the NF stay beyond 135 days from the file date or 180 days from the file date for applicants requiring a disability determination, MEPD will deny the application. Once the PSU confirms the Medicaid denial, he or she must deny Medically Dependent Children Program (MDCP) program eligibility by completing Form H2065-D, Notification of STAR + PLUS Program Services, and:

- notifies the program support interest list (PSIL) Unit by emailing the [designated box] stating that the applicant or member was denied and the reason for the denial;
- mails the original to the applicant or member;
- posts it on TxMedCentral in the MCO's STAR Kids folder, following the instructions in Appendix IX, Naming Conventions;
- emails a copy to MEPD staff; and

- uploads Form 2065-D to HEART.

If the individual, parent or guardian chooses to continue to pursue the Money Follows the Person (MFP) limited stay option after program eligibility has been denied, the MFP limited stay application process must start over. The individual may re-apply by contacting the Community Services Interest List (CSIL) Unit as described in Section 3520.1, MFP Procedures for Requesting a Limited Nursing Facility Stay, to begin the process again.

If the applicant's medical necessity (MN) has expired due to the delay in the NF stay, the MCO must complete a new SAI. If the SAI is completed within 90 days of the MEPD denial, the PSU may request that the MCO obtain a letter signed by the individual, parent or guardian requesting to reopen the Medicaid application. The MCO must post the letter to TxMedCentral in the MCO's STAR Kids folder. PSU must send the letter with Form H1746-A marked "Application." The MEPD time frame for certification will start over. If the NF stay cannot be completed within 40 days after the date of the request to reopen the Medicaid application was submitted to MEPD, the PSU must request that MEPD delay certification. However, MEPD may not approve the additional requests for delay in certification based on the amount of time that has passed since the original application file date. If MEPD denies the request to delay certification due to the age of the application, the PSU must inform the individual, parent or guardian they must complete a new Form H1200. If MEPD approves the request for delay in certification, the PSU must notify the MCO to proceed with coordination of the NF stay and enrollment procedures by posting Form H2067-MC in TxMedCentral.

Section 3000- STAR Kids Screening and Assessment and Service Planning

All children and young adults enrolled in a STAR Kids managed care organization (MCO) receive an assessment, at least annually, using the STAR Kids Screening and Assessment Instrument (SK-SAI).

3100 STAR Kids Screening and Assessment

The managed care organization (MCO) must assess each member using the STAR Kids Screening and Assessment Instrument (SK-SAI) at least annually or when the member experiences a change in condition. The assessment contains screening questions and modules that assess for medical, behavioral, and functional services.

3110 Assessment of Medical Necessity for Community First Choice

A determination of the level of care provided in a nursing facility (NF), referred to in STAR Kids as medical necessity, is required for members with a physical disability to be eligible for Community First Choice (CFC) services. STAR Kids managed care organizations (MCO) must complete the required fields for a determination of medical necessity (MN) on the STAR Kids Screening and Assessment Instrument (SK-SAI) and submit the assessment to Texas Medicaid & Healthcare Partnership (TMHP) for a determination of MN for a NF level of care. Field Z5a must be marked yes (indicated by a "1") to request TMHP review and determination of MN. A physician certification is required for all initial assessments for medical necessity for CFC services. Form 2601, Physician Certification, must be maintained in the member's file and must be obtained by the MCO and dated by the member's physician prior to the submission of the SK-SAI when Field Z5a is marked yes for initial assessments for CFC. The MCO must submit the SK-SAI to TMHP within 72 hours of completion. For the purposes of submission, an SK-SAI is only considered "complete" when the physician certification is on file in the member's case file.

If the MCO is assessing a member for CFC services for the first time, in addition to the required fields for MN, the MCO must complete the functional assessment for CFC services using the personal care assessment module (PCAM), including Section P, as well as questions in Section Z that assess for support management and emergency response services. For a member to continue to be eligible for CFC services, a determination of MN is required every 12 months. If a previous physician certification is in the member's file, a new certification is not needed.

If a member had a determination of MN approval within the last 365 days and requests CFC, the MCO completes the SK-SAI, including the PCAM and Section P, but leaves Field Z5a as marked "no" (indicated by a "0"). The MCO must note when the member's MN expires and arrange for a reassessment with the member and/or their legally authorized representative. If a member meets MN and has a need for CFC services, the MCO prepares a service plan for the member and provides an authorization to the network provider of the member's (or their legally authorized representative's (LAR)) choosing.

3120 Assessment of Medical Necessity for the Medically Dependent Children Program

A determination of the level of care provided in a nursing facility, referred to in STAR Kids as medical necessity (MN), is required for enrollment in the Medically Dependent Children Program (MDCP). STAR Kids managed care organizations (MCOs) must complete the required fields for

a determination of MN on the STAR Kids Screening and Assessment Instrument (SK-SAI) and submit the assessment to Texas Medicaid & Healthcare Partnership (TMHP) for a determination of MN for a nursing facility level of care.

Applicants or members coming off the MDCP interest list must be assessed for MN for eligibility for MDCP and the SK-SAI must be completed no later than 30 days following notification from the Program Support Unit (PSU), detailed in 2220 Managed Care Organization Coordination. The MCO must submit the SK-SAI to TMHP within 72 hours of completion. For the purposes of submission, an SK-SAI is only considered complete when the physician certification is on file. MCOs assessing applicants/members for MDCP services complete the SK-SAI, including the fields required for MN and the MDCP Module. The MCO must indicate yes on Field Z5a when seeking an MN determination from TMHP. A physician certification is required. Form 2601, Physician Certification, must be maintained in the member's file and must be obtained by the MCO and dated by the member's physician prior to the submission of the SK-SAI when Field Z5a is marked yes on initial assessments for MDCP.

If a member comes off the interest list who is receiving Community First Choice (CFC) services and has been determined to have MN within the last 365 days, the MCO completes the SK-SAI, including the MDCP module, but leaves Field Z5a as a no (indicated by a "0"). The MCO must note when the member's MN expires and arrange for a reassessment with the member and/or their legally authorized representative. A physician's certification is not required for a reassessment of MN.

Additional scenarios relating to MN determinations are available in the STAR Kids Project MCO Business Rules for SK-SAI & SK-ISP in Appendix I.

3200 Member Reassessment

All STAR Kids members are reassessed using the STAR Kids Screening and Assessment Instrument (SK-SAI) at least annually. The managed care organization (MCO) is responsible for tracking the renewal dates to ensure all member reassessment activities are completed. Failure to complete and submit timely reassessments may result in the member losing Medically Dependent Children Program (MDCP) or Medicaid program eligibility. Before the end date of the annual SK-SAI, including applicable modules, the MCO must initiate an annual reassessment to determine and validate continued need for services for each member. The MCO may not conduct the SK-SAI earlier than 90 days prior to the one-year anniversary of the member's previous assessment using the SK-SAI. For members in MDCP or receiving Community First Choice (CFC) services, reassessment must occur no later than 30 days prior to the end date of the current Individual Service Plan (ISP) on file. As part of the assessment, the MCO must inform the member about Consumer Directed Services (CDS) and Service Responsibility (SR) options. The MCO is expected to complete the same activities for each annual reassessment as required for the initial eligibility determination.

If the MCO determines the member’s health and support needs have not changed significantly within a calendar year of completing the SK-SAI based on utilization records, member reports, and provider input, the MCO may administer an abbreviated version of the SK-SAI by pre-populating the instrument with information gathered during the previous assessment and confirming the accuracy of information with the member or member’s legally authorized representative (LAR). The MCO may not administer the abbreviated SK-SAI more than once

every other calendar year and may not administer the abbreviated SK-SAI without previously completing the full SK-SAI.

For members who receive personal care services (PCS), the MCO must include the personal care assessment module (PCAM) as part of the annual SK-SAI and as requested by the member or the member's LAR. The PCAM must also be completed at any time the MCO determines the member may require a change in the number of authorized personal care service hours, such as a change of condition or change in available informal supports (e.g., changing school schedules). For members who receive nursing services, the MCO must include the nursing care assessment module (NCAM) as part of the annual SK-SAI and as requested by the member or the member's LAR. The MCO must also complete the NCAM at any time it determines the member may require a change in the number of authorized hours of nursing services, such as a change in condition.

3210 Reassessment of Medical Necessity or Level of Care

For members requiring a reassessment of medical necessity (MN) for a nursing facility level of care for continued eligibility for Community First Choice (CFC) or Medically Dependent Children Program (MDCP) services, the managed care organization (MCO) administers the entire STAR Kids Screening and Assessment Instrument (SK-SAI), including appropriate modules, no earlier than 90 days before or no later than 30 days prior to the expiration of the member's current Individual Service Plan (ISP) on file. The MCO must indicate yes in Field Z5a to notify Texas Medicaid & Healthcare Partnership (TMHP) that an MN determination is required. Form 2601, Physician Certification, is not required for reassessments of MN if the member's file contains the form for a previous assessment. The MCO must ensure that the reassessment is timed to prevent any lapse in service authorization or program eligibility.

For members receiving CFC services with a level of care for a psychiatric hospital or intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID), the MCO must remind the member and/or the member's LAR to schedule a reassessment prior to the expiration of the member's level of care assessment. The MCO must work with the mental health provider assessing for psychiatric hospital level of care, or the Local Intellectual or Developmental Disability Authority (LIDDA), assessing for an intermediate care facility (ICF) level of care.

To ensure continuity of care, the MCO must ensure that the member is reassessed for CFC and MDCP services using the STAR Kids SAI and the appropriate modules prior to the expiration date of the member's ISP. The MCO must ensure that the reassessment is timed to prevent any lapse in service authorization or program eligibility.

The Program Support Unit (PSU) must ensure the member's individual service plan (ISP) is completed annually. The PSU:

- checks the Long Term Care (LTC) portal to determine if the MCO submitted Form 2603, STAR Kids Individual Service Plan , before the ISP end date;
- verifies the case has an approved SK-SAI;
- confirms ongoing Medicaid eligibility;
- verifies the ISP is within the cost limit; and
- takes a screenshot of the ISP, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART).

If the reassessment ISP is developed but not submitted due to the member's timely appeal of a MDCP denial, the individual's services will continue using the existing ISP until a decision is received from the hearing officer. Once the hearing decision is reached the PSU and the MCO coordinate the submission of a reassessment ISP to ensure ISP records are correct and the reassessment ISP processes correctly.

If a member is reassessed and the SK-SAI is denied, the MCO must send PSU staff using Form H2067-MC, Managed Care Programs Communication, as notification to manually generate Form H2065-D, Notification of Managed Care Program Services. PSU sends Form H2065-D to the member and posts a copy to the appropriate MCO folder in TxMedCentral.

3300 Member Service Planning and Authorization

Each STAR Kids managed care organization (MCO) must create and regularly update a comprehensive person-centered individual service plan (ISP) for each STAR Kids member. Except as provided below for members receiving Medically Dependent Children Program (MDCP) services. The ISP must be completed within 90 days of completion of the initial STAR Kids Screening and Assessment Instrument (SK-SAI). The ISP must be completed within 60 days of completion of the SK-SAI for all subsequent reassessments. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and member preferences. The ISP must be used to communicate and help align expectations between the member, their legally authorized representative (LAR), the MCO and key service providers. The SK- ISP must be developed through a person-centered planning process, occur with the support of a group of people chosen by the member and their LAR, on the individual's behalf, and accommodate the member’s style of interaction, communication and preferences regarding time and setting. The STAR Kids ISP is used to:

- document findings from the SK-SAI;
- develop a plan for services received through the STAR Kids MCO;
- document services received through third party sources, such as 1915(c) waivers operated by the state;
- identify the member or applicant’s strengths, preferences, support needs and desired outcomes;
- identify what is important to the member;
- identify available natural supports available to the individual and needed service system supports;
- document the individual’s preferences for when and how to receive services;
- identify any special needs, requests, or considerations the MCO and/or providers should know when supporting the member; and
- document the member's unmet needs.

For STAR Kids members receiving MDCP services, the ISP must establish an MDCP service plan that falls within the member’s allowable cost limit. The ISP may also be used by the MCO and the state to measure member outcomes over time. The MCO must provide a printed or electronic copy of the ISP to each member or their LAR following any significant update and no less than annually within five business days of meeting with the member or their LAR. The MCO must provide a copy of the ISP to the member's providers and other individuals specified by the member or their LAR. The MCO must provide the completed ISP in the format requested. The MCO must write the ISP in plain language that is clear to the member or their LAR and, if requested, must be furnished in Spanish or other language.

The MCO service coordinator is responsible for examining the ISP for members receiving long term services and supports (LTSS) no less than three days prior to a face-to-face visit and for ensuring the document is up-to-date and adequately reflects the member's current health, goals, preferences, and needs. The MCO is responsible for developing a strategy to ensure the ISP is closely reviewed and monitored on a regular basis for members not receiving LTSS. The member's service coordinator or a representative of the MCO must review and update each member's ISP with the member and their LAR no less than annually during a face-to-face visit. The MCO must complete the ISP in an electronic format compliant with state requirements. The MCO must provide the state with information from the ISP upon request.

3310 Service Planning

All STAR Kids narrative individual service plans (ISPs) must be developed using person-centered practices. Form 2603, STAR Kids Individual Service Plan (ISP)- Narrative Form is designed to complement the STAR Kids Screening and Assessment Instrument (SK-SAI) and where appropriate, the instructions note where information may be copied from the appropriate fields of the SK-SAI. At a minimum, the ISP must account for the following information:

- a summary document describing the recommended service needs identified through the SK-SAI;
- covered services currently received;
- covered services not currently received, but that the member might benefit from;
- a description of non-covered services that could benefit the member;
- member and family goals and service preferences;
- natural strengths and supports of the member including helpful family members, community supports, or special capabilities of the member;
- a description of roles and responsibilities for the member, their legally authorized representative (LAR), others in the member's support network, key service providers, the member's health home, the managed care organization (MCO), and the member's school with respect to maintaining and maximizing the health and well-being of the member;
- a plan for coordinating and integrating care between providers and covered and non-covered services;
- short and long-term goals for the member's health and well-being;
- if applicable, services provided to the member through waiver programs not operated by the MCO, or third-party resources, and the sources or providers of those services;
- plans specifically related to transitioning to adulthood for members age 15 and older; and
- any additional information to describe strategies to meet service objectives and member goals.

The ISP must be informed by findings from the STAR Kids Screening and Assessment Process (SK-SAP), in addition to input from the member; their family and caretakers; providers; and any other individual with knowledge and understanding of the member's strengths and service needs who is identified by the member, the member's LAR, or the MCO. To the extent possible and applicable, the ISP must also account for school-based service plans and service plans provided outside of the MCO. The MCO is encouraged to request, but may not require the member to provide a copy of the member's Individualized Education Plan (IEP).

The MCO must list Medicaid state plan services the member is receiving or is approved to receive, including service type, provider, hours per week (if applicable), begin/end date, and whether the member has chosen the Consumer Directed Services (CDS) or Service Responsibility Option (SRO) (if applicable). The MCO must also include a brief rationale for the services. The MCO should also list services provided by third-party resources, like Medicare or available community services. This form is updated, per Section 3311, Updates to the ISP, and is maintained in the member's case file.

3311 Updates to the Individual Service Plan

Each member's individual service plan (ISP) must be updated at least annually, or sooner in the following situations within 14 calendar days of request or notification of a need or a change:

- following a significant change in health condition that impacts service needs;
- upon request from the member or their legally authorized representative (LAR);
- at the recommendation of the member's primary care provider and/or health home; and
- following a change in life circumstance.

3320 Service Planning for Medically Dependent Children Services

The service coordinator must work with the member and/or member's legally authorized representative (LAR) to create an individual service plan (ISP) including Medically Dependent Children Program (MDCP) services that do not exceed the member's cost limit. Only MDCP services count toward the cost limit. The cost limit is based on the member's Resource Utilization Group (RUG), which is determined based on the STAR Kids Screening and Assessment Instrument (SK-SAI). Cost limits associated with each RUG may be found in Appendix VIII, Resource Utilization Groups (RUG) Individual Plan of Care (IPC) Cost Limits

The service coordinator documents these MDCP services on Form 2603, STAR Kids Individual Service Plan (SK-ISP) - Narrative Form. The form must list the MDCP services the member is receiving or approved to receive, including service type, provider, hours per week (if applicable), begin/end date, and whether the member has chosen the Agency Option (AO), Consumer Directed Services (CDS), or Service Responsibility Option (SRO) (if applicable). The form must also include a brief rationale (i.e., why the service is needed or requested).

The list of MDCP services on Form 2603 must match the services submitted with the electronic ISP. For new MDCP members coming off the interest list, the MCO completes and submits the electronic SK-ISP within 60 days of the initial notification from the Program Support Unit (PSU). For all current MDCP members, the MCO completes and submits the electronic SK-ISP within 60 days following receipt of a response to the SK-SAI submission. The response file from Texas Medicaid & Healthcare Partnership (TMHP) contains the determination of medical necessity and the member's RUG. The start date for the SK-ISP must be the first day of the next month. If a Medicaid eligibility determination is required, the start date of the SK-ISP is the first day of the month following a determination of Medicaid eligibility. An ISP is valid for one year.

When the member's SK-ISP is complete and within the member's established cost limit, the MCO submits the SK-ISP to TMHP. The MCO must submit the SK-ISP prior to the start date of the member's ISP and follow the instructions in Appendix I, STAR Kids Project MCO Business

Rules for SK-SAI & SK-ISP. The MCO must retain a copy of Form 2406, Physician Recommendation for Length of Stay in a Nursing Facility in the member's file.

If the member is turning 21 in less than one year, resulting in an ISP year that is less than twelve months, the MCO must prorate the member's cost limit. To calculate the prorated cost, the MCO must:

- divide the cost limit by the total number of days in a year (365 days);
- determine the total number of days beginning with the start date of the individual plan of care (IPC) and ending with the date before the member's 21st birthday; and
- multiply the figure from Step 1 and the figure from Step 2 above to get the cost limit for the ISP period for which the member is eligible.

Example: The member's 21st birthday is July 9, and the ISP start date is April 1, and the end date will be on July 8. The member's cost limit is $25,000.

- Step 1: $25,000 ÷ 365 days = $68.49 per day
- Step 2: The number of days per month: April = 30, May = 31, June = 30, July 1-8 = 8, for a total of 99 days.
- Step 3: $68.49 × 99 = $6,780.51

$6,780.51 is the prorated cost limit for the individual for the ISP.

3321 Medically Dependent Children Program Individual Service Plan Revision

If a member and/or their legally authorized representative (LAR) request a change to the member's Medically Dependent Children Program (MDCP) service plan, but the member has not experienced a change in condition that affects their Resource Utilization Group (RUG), and thus their cost limit, the managed care organization (MCO) must respond to the request **within 14 calendar days.**

To revise a member's MDCP individual service plan (ISP) when there is no change in the member's RUG, the MCO updates Form H2603 and submits the SK-ISP to Texas Medicaid and Healthcare Partnership (TMHP) with the updated services and a revised begin date. The MCO maintains the updated Form H2603 in the member's file.

3322 Medically Dependent Children Program Individual Service Plan and Budget Revision

If a member and/or their legally authorized representative (LAR), the member's provider or the managed care organization (MCO) service coordinator notify the MCO about a change in the member's condition that may affect the Resource Utilization Group (RUG), and thus their cost limit, the managed care organization (MCO) must reassess the member within 14 calendar days. The MCO must complete the STAR Kids Screening and Assessment Instrument (SK-SAI), including the MDCP module, and complete the following fields according to Appendix I, STAR Kids Project MCO Business Rules for SK-SAI & SK-ISP:

- A10c = Medicaid number of the individual
- A12 = 2 (Significant Change in Status Reassessment)
- Z5a = 0 (No)
- Z5b = 0 (No)

Following receipt of a response file indicating the member's new RUG and associated cost limit, the MCO completes a new STAR Kids individual service plan (SK-ISP) that reflects the member and/or their legally authorized representative's goals, preferences, and needs within the new cost limit. The MCO must subtract the cost of services provided under the original ISP and subtract that amount from the member's new cost limit to assess available funds for the remainder of the ISP period. The MCO must document how the available funds for the ISP period were determined and maintain documentation in the member's case file.

If a member will turn 21 between the start and end date of the member's ISP, the MCO should ensure any necessary adaptive aids, minor home modifications, or transition assistance are provided prior to the member's birthday. If the MCO authorizes adaptive aids, minor home modifications, or transition assistance, the MCO remains responsible for payment for those services, including applicable warranties.

3323 Setting Aside Funds in the Medically Dependent Children Program Individual Service Plan

Managed care organizations may permit a Medically Dependent Children Program (MDCP) member or their legally authorized representative to set aside MDCP funds, within the approved cost limit, for use later in the individual service plan (ISP) period. If a member or their legally authorized representative (LAR) choose to set aside funds, the MCO must document the member or LAR's preferences and maintain documentation in the member's case file. A member or their LAR may not carry forward funds between ISP periods.

3324 Individual Service Plan Exceeding the Cost Limit for Medically Dependent Children Program Services

If the individual service plan (ISP) cost exceeds 50 percent of the Resource Utilization Group (RUG) cost limit, the managed care organization (MCO) submits via email the following documents to the Texas Health and Human Services Commission (HHSC) Utilization Review (UR) Transition/High Needs Coordinator:

- STAR Kids Screening and Assessment Instrument (SK-SAI)
- STAR Kids Individual Service Plan (SK-ISP) and any Addendums
- Medical records (nursing care plan, recent care notes, doctor's orders and nursing notes)
- Form H1024, Consumer Summary Report

HHSC UR may request a clinical review of the case to consider the use of State General Revenue funds to cover costs exceeding 50 percent cost limit. If a clinical review is conducted, HHSC will provide a copy of the final determination letter to the MCO and the Program Support Unit (PSU).

Note: MCOs must not discuss with applicants/members, or request use of State General Revenue funds for services above the cost ceiling.

3325 Multiple Medically Dependent Children Program Members in the Same Household

In some instances, multiple members receiving Medically Dependent Children Program (MDCP) services may live in the same household. In those instances, the STAR Kids managed care

organization (MCO) is responsible for ensuring any MDCP services for more than one member in the same household delivered concurrently are provided in a way the protects the health and safety of each of those members.

In such cases, the MCO may allow MDCP services to be provided in a member to provider ratio other than one-to-one, as long as:

- Each member's care is based on his or her an individual service plan; and
- Each client's needs are being met.

Example: The parents of Sarah and James, a brother and sister, are scheduled to receive respite services from 8am to 2pm every other Saturday. Sarah requires ventilator support, medication administration through a gastrostomy tube, and suctioning as needed. James requires assistance with ambulation, toileting, and eating. In this situation, the MCO should authorize the appropriate level of staffing to meet Sarah's and James's needs to prevent provider overlap.

3326 Suspension of Medically Dependent Children Program Services

To remain eligible for Medically Dependent Children Program (MDCP) services, a member must receive one MDCP service monthly. In the event that the member travels out of state, is admitted to a hospital or nursing facility (NF), or is unable to receive a waiver service in a particular month, the STAR Kids managed care organization (MCO) must document the suspension of waiver services in the member's case file. The MCO must document:

- The dates during which services are suspended; and
- The reason for suspension.

A member may not have services suspended longer than 90 days. If a member's services are suspended 91 days or more, the MCO must notify the Program Support Unit (PSU) using Form H2067-MC, Managed Care Communication, and request closure of MDCP enrollment, following procedures in Section 2000. Closure of MDCP enrollment may result in disenrollment from STAR Kids, loss of Medicaid eligibility, or both.

3327 Reassessment Individual Service Provider Procedures

The Program Support Unit (PSU) must ensure the member's individual service plan (ISP) is authorized annually. The PSU:

- checks TxMedCentral to determine if the managed care organization has submitted Form 2603, SK-ISP, before the ISP end date;
- verifies the case has an approved Star Kids Screening and Assessment Instrument (SK-SAI);
- confirms ongoing Medicaid eligibility; and
- verifies the ISP is within the cost limit.

If the reassessment ISP is developed but not submitted due to the member's timely appeal of a MDCP denial, the individual's services will continue using the existing ISP until a decision is received from the hearing officer. Once the hearing decision is reached the PSU and the MCO

coordinate the submission of a reassessment ISP to ensure ISP records are correct and the reassessment ISP processes correctly.

3328 Reassessment Notification Requirements

If the member continues to meet waiver requirements, it is not necessary to send Form H2065-D, Notification of Managed Care Program Services, at the reassessment as notification of continuing services. If the member does not meet waiver requirements, the Program Support Unit (PSU) must, within two business days of notification:

- send Form H2065-D to the member indicating why the case is being terminated;
- terminate the ISP through the Long Term Care (LTC) Portal and generates Form H2065-D through the portal, if available. PSU posts Form H2067-MC, Managed Care Programs Communication, to TxMedCentral to alert the MCO the denial notice is available in the LTC portal; and
- send a copy of Form H2065-D to Enrollment Resolution Services for medical assistance only (MAO) members (HPO_STAR_PLUS@hhsc.state.tx.us).

If the member files an appeal timely, the PSU, within two business days of notification:

- sends Form H1746-A, MEPD Referral Cover Sheet, for cases in the Centralized Representation Unit, which forwards the information to the appropriate MEPD specialist;
- posts Form H2067-MC, STAR + PLUS Communication, in TxMedCentral to the XXXSPW folder, using the appropriate naming convention, informing the managed care organization (MCO) to continue services due to the timely appeal (if services have already ended, the MCO reinitiates services immediately);
- extends the end date of the current individual service plan (ISP) an additional four calendar months; and
- sends an email to Enrollment Resolution Services on Medical Assistance Only cases as notification that a timely appeal was submitted and enrollment should remain open.

Enrollment Resolution Services carries out the decision within 10 calendar days of receiving the fair hearings officer's decision.

3400 Member Transfers

3410 Transfer from One Managed Care Organization to Another

Once the initial enrollment period of one calendar month is passed, a member is eligible to change managed care organization (MCO) plans. When a member or their legally authorized representative (LAR) chooses to change from one MCO to another MCO in the same delivery area, the member or responsible party must contact the state-contracted enrollment broker via phone call to 1-800-964-2777, or via written correspondence.

The member can request to change MCOs as many times as the member wants, but the change cannot be made more than once per month. If the member calls to change the MCO on or before the 15th day of the month, the change will take place on the first day of the next month. If the member calls after the 15th day of the month, the change will take place the first day of the second month following the change request.

Examples:

- If the member calls on or before April 15, the change will take place on May 1.
- If the member calls after April 15, the change will take place on June 1.

Health and Human Services Commission (HHSC) –Operations prepares and sends the Monthly Plan Changes report to the Program Support Unit (PSU). The PSU receives a full list and shares MCO specific information with Health Plan Management (HPM), who shares it with MCOs. The MCO receives a member-specific report. The report gives a list of STAR Kids members who have changed MCOs from the previous month.

To prevent duplication of activities when a member changes MCOs, the former, or "losing," MCO must provide the receiving, or "gaining," MCO with information concerning the results of the MCO's identification and assessment upon the gaining MCO's request. Within five business days of receiving the list of members changing MCOs, the gaining MCO must request any documentation in the member's case file from the losing MCO, such as the member's narrative individual service plan (ISP) (Form 2603). Within five business days of receiving the request, the losing MCO must provide the requested documents to the gaining MCO. The gaining MCO must ensure the member's new service coordinator, once assigned, contacts the member's former service coordinator at the losing MCO to ensure a seamless transition of service coordination. The gaining MCO must contact the losing MCO for additional information maintained in the member's case file. If the gaining MCO experiences issues obtaining this information, they must notify HHSC HPM.

HPM must contact the losing MCO and require the MCO to upload information contained in the member's file, including the narrative STAR Kids ISP and any current authorizations, within two business days of notification. HPM informs PSU by email the date by which the MCO must upload the information to TxMedCentral. PSU transfers the information from the losing MCO to the gaining MCO within two business days of notification from HPM. The STAR Kids screening and assessment instrument (SK-SAI) and electronic ISP, as well as historical SK-SAIs and ISPs, will be available to the gaining MCO upon enrollment through the TMHP Portal.

The gaining MCO is responsible for service delivery from the first day of enrollment. Within five business days of enrollment of the new member, the gaining MCO must contact the member to discuss services needed by the member. Within 15 business days of enrollment of the new member, the gaining MCO must conduct a home visit to assess the member's needs. For continuity of care, this includes authorizations, additional assessments, and pending delivery of adaptive aids, minor home modifications, or transition assistance. This home visit may include conducting the SK-SAI if the member is due for a new assessment, has experienced a significant change in condition, or if otherwise deemed necessary by the gaining MCO. The gaining MCO must adhere to all rules for SK-SAI processing related to member transfers outlined in the SK-SAI business rules.

The gaining MCO must provide services and honor authorizations included in the prior ISP until the member requires a new assessment or until the gaining MCO is able to complete their own STAR Kids Screening and Assessment Process (SK-SAP), update the ISP, and issue new service authorizations. The gaining MCO must allow the member to continue to receive services with his or her existing provider and allow an out-of-network authorization to ensure the member's condition remains stable and services are consistent to meet the member's needs. If the gaining MCO is in a different service delivery area because the member moved, the gaining

MCO assists the member in locating providers immediately upon request from the member or their legally authorized representative. Out-of-network authorizations must continue until the existing service plan expires or the gaining MCO can provide comparable services to transition the member to a provider who will be able to meet the member's complex needs.

3420 Member transferring from waiver program to Medically Dependent Children Program

Participants in other 1915(c) Medicaid waivers operated by the state may be on the interest list for the Medically Dependent Children Program (MDCP). If a STAR Kids member in another Medicaid waiver program comes up on the interest list for MDCP, a referral is made to the Program Support Unit (PSU).

PSU specialists are responsible for completing the following activities within 14 days of the initial request for an MDCP assessment. All attempted contacts with the member or encountered delays must be documented. The PSU:

- contacts the member and explains MDCP services; and
- sends a copy of the STAR Kids managed care organization (MCO) provider directories and comparison chart to the 1915(c) waiver member.

Within two business days of notification of the MCO selection by the waiver member, PSU completes Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization, and posts it in the XXXSPW folder on TxMedCentral, using the appropriate naming convention.

The MCO completes:

- the STAR Kids Screening and Assessment Instrument (SK-SAI), including the MDCP module;
- Form 2603, STAR Kids Individual Service Plan (SKISP) and posts to TxMedCentral.

If the information from the MCO is not received within 45 days after the assessment is authorized, PSU emails the assigned health plan manager as notification the time frame for completing the ISP was not met.

Within two business days of receipt of all required waiver eligibility documentation, PSU determines waiver eligibility based upon medical necessity and an ISP cost within the Resource Utilization Group cost limit.

If eligibility for MDCP is denied or the individual decides not to accept MDCP services, the PSU:

- completes Form H2065-D, Notification of Managed Care Program Services;
- mails the original to the 1915(c) Waiver individual, with the explanation that this finding does not affect eligibility for the service the individual is currently receiving;
- notifies the MCO by posting a copy to TxMedCentral; and
- uploads the Form H2065-D to the Health and Human Services (HHS) Enterprise Administrative Record and Tracking system (HEART).

If eligibility is approved and the individual chooses to accept MDCP services, the individual is enrolled in MDCP the first day of the next month. Within two days of determining the start of care date for MDCP services, PSU:

- completes Form H2065-D;
- mails the original to the 1915(c) waiver recipient;
- notifies the MCO by posting a copy to TxMedCentral; and
- notifies Enrollment Resolution Services by emailing HPO_Star_Plus@hhsc.state.tx.us.

PSU staff must coordinate with staff and providers, as appropriate, to ensure the current 1915(c) Waiver services end the day before enrollment in MDCP.

3440 Member transfer from MDCP to another waiver

STAR Kids member receiving Medically Dependent Children Program services (MDCP) may be on an interest list for another Medicaid program such as Community Living and Support Services (CLASS) or Home and Community based Services (HCS). Texas Health and Human Services Commission (HHSC) informs the managed care organization (MCO) that a member receiving MDCP services has come to the top of the interest list for another program and is assessed as eligible for that program, the service coordinator or case manager must contact the Program Support Unit to assist in coordinating the end of MDCP services the day prior to the member's enrollment in the new program. Program support unit (PSU) must coordinate with the member's MCO about the end of MDCP services and the member's transition to another waiver. The member remains in the same STAR Kids MCO they are currently enrolled in for their state plan services.

PSU specialists are responsible for completing the following activities within 14 days of the initial request for an MDCP assessment. All attempted contacts with the member or encountered delays must be documented. The PSU:

- creates a case in the HHS Enterprise Administrative Report and Tracking System (HEART);
- checks the Community Services Interest List (CSIL) to see if the member is on a 1915(c) interest list;
- confirms if the member has an open enrollment with another 1915(c) waiver program according to the procedures below:
    - For either the Texas Home Living (TxHmL) or Home and Community-based Services Waivers (HCS), check the Client Assignment and Registration (CARE) System, Screen 397 series, Client ID Information Screens, to verify whether a member is enrolled in one of these programs. The screen specific to "waiver consumer assignment history" identifies enrollment, when applicable.
- For the CLASS (Service Group 2) and Deaf Blind with Multiple Disabilities (DBMD) (Service Group 16) Waiver programs, check the Service Authorization System (SAS) to verify the service authorization record for these waivers;
- moves interest list with an "assessment requested" notation; close the MDCP release in the CSIL system effective the date of the notification from the MCO informing of the member's decision to transfer to another waiver program;
- sends Form 2442, Notification of Interest List Release Closure, to the member notifying of the MDCP closure. If the CLASS or other waiver program application is denied, Form 2442 will instruct the member to contact the CSIL if he/she wishes to apply for MDCP. When the member contacts CSIL, he/she will be reinstated on the MDCP interest list.

3450 Member transfer from Community Services to STAR Kids

The Program Support Unit (PSU) must coordinate the termination of other waiver or Community Care for the Aged and Disabled (CCAD) services with the CCAD case manager so that the individual does not experience a break in services and does not receive concurrent services through another waiver or CCAD service.

For individuals just entering STAR Kids through the Medically Dependent Children Program (MDCP), the PSU coordinates the termination of other waiver or CCAD services with the waiver or CCAD case manager. This ensures the individual does not experience a break in services and does not receive concurrent services through another waiver or CCAD service.

The case manager must send Form 2065-E, Notification of In-Home Family Support Program Benefits, to initiate denial. It is not necessary to provide an adverse action period prior to closing the authorization in the Service Authorization System.
CCAD services are terminated by the CCAD case manager no later than the day prior to MDCP enrollment. This is crucial since no MDCP member may receive CCAD and MDCP services on the same day.

3500 Member Transition to Adult Programs

Per the STAR Kids Managed Care Contract, all STAR Kids members begin transition services when they are 15 years of age and periodically meet with a transition specialist to plan their transition to adulthood. Members who receive Medically Dependent Children Program (MDCP) Services, Private Duty Nursing (PDN), Community First Choice (CFC) or Personal Care Services (PCS) and are transitioning to adult programs may apply for services through STAR+PLUS including STAR+PLUS Home and Community Based Services (HCBS) Program, in order to continue receiving community-based services and avoid institutionalization beginning the 1st of the month following their 21st birthday.

3510 Procedures for Children Transitioning from STAR Kids Receiving Medically Dependent Children Program, Private Duty Nursing, Prescribed Pediatric Extended Care Centers, or Community First Choice

Below is a list of possible waiver and service combinations the member may be receiving prior to transition:

- Medically Dependent Children Program (MDCP) only
- Private Duty Nursing (PDN) or Prescribed Pediatric Extended Care Center services (PPECC) only
- MDCP with either or both of the following services:
    - Personal Care Services (PCS)
    - PDN/PPECC
- MDCP with Community First Choice (CFC) services
- PDN/PPECC with PCS
- PDN/PPECC with CFC services

3511 Twelve Months Prior to the Member's 21st Birthday

Twelve months prior to the 21st birthday of a member receiving services from the Medically Dependent Children Program (MDCP), Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (PPECC) services or Community First Choice (CFC) the following process begins.

Each quarter, the Program Support (PS) and Utilization Review (UR) department provides a copy of the STAR Kids (SK) Transition Report, which lists individuals enrolled in STAR Kids and receiving MDCP and/or PDN/PPECC and/or CFC who may transition to STAR+PLUS or STAR +PLUS Home and Community Based Services (HCBS) Program in the next 18 months, to the:

- Program Support Interest List (PSIL) manager; and
- Utilization Management and Review (UMR) department for the Intellectual and Developmental Disability (IDD) 1915 (c) waivers.

Procedures for managing this report, including timeframes, can be found in Appendix VI, Reporting Requirements for the STAR Kids (SK) Transition Report.

The managed care organization (MCO) identifies all members turning 21 within the next 12 months and schedules a face-to-face visit with the member and the member's available supports, including their legally authorized representative if applicable, to initiate the transition process.

During the home visit with the member and their supports, the MCO must present an overview of STAR+PLUS program, including STAR+PLUS HCBS and the changes that will take place the first of the month following the member's 21st birthday. The points to be discussed are:

- STAR Kids eligibility, MDCP or PDN terminate on the last day of the month in which their 21st birthday occurs.
- STAR+PLUS HCBS may be an option available to the individual at age 21. The MCO must also present an overview of the array of services available in STAR+PLUS HCBS.
- Children's services, such as PDN and MDCP, are not available to adults. For individuals receiving PDN, STAR+PLUS HCBS or an intellectual or developmental disability (IDD) waiver will need to cover medically necessary nursing services that are not intermittent or part-time at age 21, which may not be the same level of nursing they receive through STAR Kids. To be eligible for STAR+PLUS or the IDD waiver, the individual's health and safety must be ensured under the cost limit for the waiver program.
- Assist the member with looking for an adult Primary Care Physician (PCP), specialists as necessary, and a dentist.
- Provide information and referrals to community organizations that are important to the health and wellbeing of members. These organizations include but are not limited to:
    - State/federal agencies (e.g., those agencies with jurisdiction over aging , public health, substance abuse, mental health, IDD, rehabilitation, income support, nutritional assistance, family support agencies, etc.) For members with progressive vision loss, a referral is made to explore services offered through Texas School for the Blind and Visually Impaired;

    - Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);
    - City and county agencies (e.g., welfare departments, housing programs, etc.);
    - Civic and religious organizations; and
    - Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.)
- Discuss current and possible future community living options. Coordinate visits with potential providers or facilities, if applicable
- Assess member's needs for adaptive aids, new equipment due to growth and development, and minor home modifications, as necessary.
- Discuss guardianship
- Transition activities will begin no later than nine months prior to their 21st birthday.
- The PSU will send STAR+PLUS enrollment packets (containing the STAR+PLUS MCO list and a comparison chart) to the individual nine months prior to their 21st birthday.
- The importance of choosing an MCO six months before the 21st birthday in order to avoid being assigned an MCO or having a gap in services.
- The member and available supports can change MCOs any time after the first month of enrollment.
- STAR+PLUS HCBS Program has a cost limit based on a medical assessment, the Medical Necessity/Level of Care (MN/LOC) Assessment. The limit is 202% of the member's Resource Utilization Group (RUG).The assessment results in the cost limit for the annual individual service plan (ISP).
- To be eligible for STAR+PLUS HCBS Program, an ISP must be developed within the cost limit that will meet the individual's needs and ensure health and safety.
- If an ISP cannot be developed within the cost limit that ensures the health and safety, STAR+PLUS HCBS Program will be denied.
- The ISP considers all resources available to meet the member's needs, including community supports, other programs, and what the member's informal support system can provide to meet the member's needs.
- The STAR+PLUS HCBS Program assessment process will begin six months before the individual's 21st birthday. The PSU will contact the member to begin the assessment process and find out which STAR+PLUS MCO has been selected. If an MCO has not been selected, then 30 days is allowed for a selection. After 30 days, an MCO is selected for the individual.
- After the STAR+PLUS MCO is selected, the MCO will contact the individual to begin the assessment for services and assist the member and available supports in identifying and developing additional resources and community supports to help meet the individual's needs.

STAR Kids MCO:

- Makes a referral to the PSU vial email at: ManagedCareProgramSupport@hhsc.state.tx.us using Form H2067-MC, STAR+PLUS Communications and include "PDN and/or MDCP" Transition in the subject line;
- Monitors service planning with the member/available supports every 90 days during the year before the member turns 21;

- Notifies the Texas Health and Human Services Commission (HHSC) Program Support and Utilization Review Transition/ High Needs Coordinator by email this may be a high needs individual, if the member appears to meet the criteria in STAR+PLUS Handbook, Appendix XIV, Determination of High Needs Status for the HCBS STAR+PLUS Waiver (SPW).

Program Support Unit staff for STAR+PLUS Home and Community Based Service:

- monitors the SK Transition Report and identifies all individuals referenced in Section 3510, Procedures for Children Transitioning from STAR Kids Receiving medically dependent children program (MDCP), private duty nursing (PDN) or community first choice (CFC), turning 21 in 12 months and not enrolled in one of the following intellectual or developmental disabilities (IDD) 1915 (c) waivers:
    - Community Living Assistance and Support Services (CLASS);
    - Deaf Blind and Multiple Disabilities (DBMD);
    - Home and Community-based Services (HCS); and
    - Texas Home Living (TxHmL);
- creates a case in the HHS Enterprise Administrative Report and Tracking System (HEART) noting:
    - if the managed care organization (MCO) determines the individual is high needs;
    - the program type (MDCP, CFC or PDN/PPECC) transitioning from; and
    - the due date for the 9-month contact; and

The following chart outlines the responsibilities for monitoring the SK Transition report and contacting members transitioning from STAR Kids who receive MDCP Waiver, PDN or PPECC, or CFC within the next 12 months:

Twelve Month Transition Chart

< age 21 MDCP Waiver	**< age 21 Other Services Received**	**Monitors SK Report:**	**12-Month Contact:**
MDCP	PDN/PPECC	PSU Specialist	STAR Kids MCO
MDCP	CFC	PSU Specialist	STAR Kids MCO
MDCP	PCS	PSU Specialist	STAR Kids MCO
MDCP	PDN/PPECC and CFC	PSU Specialist	STAR Kids MCO
MDCP	PDN/PPECC and PCS	PSU Specialist	STAR Kids MCO
MDCP	None	PSU Specialist	STAR Kids MCO
None	PDN/PPECC	PSU Specialist	STAR Kids MCO

< age 21 MDCP Waiver	< age 21 Other Services Received	Monitors SK Report:	12-Month Contact:
None	PDN/PPECC and CFC	PSU Specialist	STAR Kids MCO
None	PDN/PPECC and PCS	PSU Specialist	STAR Kids MCO

3512 STAR+PLUS Transition Activities

The Program Support staff for STAR+PLUS Home and Community Based Services (HCBS) will follow the STAR+PLUS enrollment guidelines as outlined in the STAR+PLUS Handbook, Section 3420, Individuals Transitioning to an Adult Program.

3513 Intrapulmonary Percussive Ventilator Benefit

Reserved

3530 Procedures for Non-Waiver Members Transitioning from STAR Kids with Personal Care Services only services Twelve Months Prior to the Member's 21st Birthday

3531 Twelve Months Prior to the Member's 21st Birthday

The Managed Care Organization (MCO) identifies all members turning 21 and receiving personal care services (PCS) only within the next 12 months and schedules a face-to-face visit with the member and available supports to initiate the transition process.
During the home visit with the member and available supports, the MCO must present an overview of STAR+PLUS program, including STAR+PLUS Home and Community Based Services (HCBS) and the changes that will take place the first of the month following the member's 21st birthday. The points to be discussed are as follows:

- STAR Kids eligibility will terminate on the last day of the month in which their 21st birthday occurs.
- PCS is a benefit of the STAR+PLUS program
- An enrollee in STAR+PLUS may request an upgrade to STAR+PLUS HCBS. (Supplemental Security Income (SSI) individuals do not have to go on the STAR+PLUS HCBS Interest list)
- Maximus will reach out to the individual 30 days prior to the individuals 21st birthday and provides the individual with STAR+PLUS enrollment packets (containing the STAR+PLUS MCO list)
- If an MCO has not been selected, then 15 days is allowed for a selection. After 15 days, an MCO is selected for the individual.
- The effective date for the STAR+PLUS enrollment will be the 1st of the month following their 21st birthday.

3531 Thirty Days Prior to the Member's 21st Birthday

MAXIMUS will reach out to the individual 30 days prior to the member's 21st birthday and provides the member with STAR+PLUS enrollment packets (containing the STAR+PLUS managed care organization (MCO) list). If an MCO is not selected, then 15 days is allowed for a selection. After 15 days, an MCO is selected for the individual.

The Program Support Unit (PSU) will update the monthly Personal Care Services (PCS) Authorization report with the MCO selection and send PCS authorization information to the STAR+PLUS plan prior to the enrollment effective date. The STAR+PLUS MCO must honor the existing prior authorization as required by contract.

Section 4000 STAR Kids Community Services

This section outlines the delivery of STAR Kids community long term services and supports. Section 4100-4500 describes Medicaid state plan long term services and supports, assessment and reassessment requirements, and provider requirements.

Section 4600-4900 describe services available to members receiving Medically Dependent Children Program (MDCP) services, service requirements and limitations, and provider requirements.

4100 Community First Choice

Community First Choice (CFC) is a group of services, described in more detail below delivered under the authority of §1915(k) of the Social Security Act. CFC is under the federal regulations governing home and community based services. Therefore, the settings in which CFC is delivered must be compliant with the Title 42 Code of Federal Regulations (CFR) §441.301(c)(4) and §441.710 respectively. Permissible home and community based settings include member homes, apartment buildings, and non-residential settings. Community-based settings exclude:

- nursing facilities;
- hospitals providing long-term care services;
- inpatient psychiatric facilities;
- intermediate care facility for individuals with an intellectual disability or a related condition (ICF-IID); or
- a setting on the grounds of or with the characteristics of an institution.

Provider owned and controlled settings are also excluded from CFC because those providers are paid for CFC-like services as part of their rates and to provide CFC would be duplicative.

In addition, assessment for CFC services and the development of a member's service plan must be person-centered, per 42 CFR §441.665.

4110 Community First Choice Eligibility

Eligibility for Community First Choice (CFC) requires a STAR Kids member meet the following conditions:

- Be Medicaid eligible;
- Meet the level of care provided in a hospital or nursing facility (NF), intermediate care facility for individuals with an intellectual disability or a related condition (ICF/IID) or an institution providing psychiatric services; and
- Have an assessed, functional need for CFC services.

All STAR Kids members are Medicaid eligible. Members whose eligibility is established due to eligibility for the Youth Empowerment Services (YES) or Medically Dependent Children Program (MDCP) waivers are eligible for CFC services, per § 1902(a)(10)(A)(ii)(VI), of the Social Security Act, as long as they receive at least one waiver service per month, as these members meet eligibility for an institution providing psychiatric services and a nursing facility (NF), respectively.

A member may not be authorized to receive both personal care services (PCS) and CFC services at the same time.

Members who receive services through the following 1915(c) waiver programs receive CFC services through their waiver provider and are not eligible to receive CFC through the managed care organization (MCO):

- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS); and
- Texas Home Living (TxHmL)

4111 Determining Institutional Level of Care

STAR Kids Screening and Assessment Instrument

For members with physical disabilities, the STAR Kids Screening and Assessment Instrument (SK-SAI) contains the elements necessary for Texas Medicaid & Healthcare Partnership (TMHP), on behalf of the Health and Human Services Commission (HHSC), to determine if a member meets medical necessity for the level of care provided in a hospital or nursing facility. Once the SK-SAI is completed, if the STAR Kids managed care organization (MCO) seeks a determination of medical necessity for community first choice (CFC) services, the MCO must indicate so before submitting the assessment. The MCO must obtain the member's physician's signature on Form 2601, Physician Certification, certifying the member's requires nursing facility (NF) services or alternative community based services under the supervision of a physician.

Further information about the medical necessity determination process for CFC may be found in Section 3110, Assessment of Medical Necessity for Community First Choice.
Intellectual Disability or Related Condition Assessment.

Upon notification from the MCO, Local Intellectual or Development Disability Authorities (LIDDAs) conduct assessments to determine whether a member meets the level of care (LOC) provided by an intermediate care facility for individuals with intellectual disabilities or a related condition (ICF/IID). In addition to the Intellectual Disability/ Related Condition assessment (ID/RC), the LIDDA must collect information necessary to complete a Determination of Intellectual Disability (DID), if a member does not have one on file. The LIDDA submits this information to the state for a determination of intellectual disability or related condition. The state notifies both the LIDDA and the member's managed care organization (MCO) about the determination. If a member meets the LOC provided in an ICF/IID, the MCO completes the CFC functional assessment. If the member does not agree to the CFC service plan or refuses CFC services, the MCO must notify the LIDDA within 10 business days of the member ending CFC services.

Child and Adolescent Needs and Strengths or Adult Needs and Strengths Assessment

A comprehensive provider of mental health rehabilitative services or a Local Mental Health Authority (LMHA) conduct the Child and Adolescent Needs (CANS) or Strengths or Adult Needs and Strengths Assessment (ANSA) and a licensed practitioner determines whether the member meets an inpatient psychiatric facility level of care. If the member meets that LOC, or receives

services through the Youth Empowerment Services program, the MCO conducts the CFC functional assessment if the member requests CFC services.

4120 Community First Choice Services

Community First Choice services are personal assistance services, habilitation, emergency response service, and support management.

4121 Community First Choice Personal Assistance

Community First Choice personal assistance service (PAS) provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing. Such assistance is provided to a member in performing ADLs and IADLs based on a person-centered service plan. CFC personal assistance services include:

- Non-skilled assistance with the performance of ADLs and IADLs;
- Household chores necessary to maintain the home in a clean, sanitary, and safe environment;
- Escort services, which consist of accompanying, but not transporting, and assisting a member to access services or activities in the community; and
- Assistance with health-related tasks. Health-related tasks, in accordance with state law, include tasks delegated by a registered nurse, health maintenance activities, and extension of therapy. An extension of therapy is an activity that a speech therapist, physical therapist or occupational therapist instructs the member to do as follow-up to therapy sessions. If appropriate, the member's attendant can assist the member in accomplishing such activities with supervision, cueing and hands-on assistance.

In the consumer-directed services (CDS) model, the member or legally-authorized representative (LAR), determines health-related tasks without a nurse assessment, in accordance with state law (§531.051(e), Texas Government Code and 22 Texas Administrative Code, §225.4.).

CFC PAS is the same service (i.e., attendant care) as personal care services (PCS). The only difference is the member's level of care (LOC) and how the service is billed. Information used to build a plan of care for CFC PAS may be found in the STAR Kids Screening and Assessment Instrument (SK-SAI) Personal Care Assessment Module (PCAM). The PCAM is administered if triggered by the appropriate items on the SK-SAI (please see the SK-SAI Document Map in the Appendix) or if the member requests CFC services. Although the PCAM may be triggered if the member has an attendant care need, they may only receive CFC PAS if they meet CFC level of care criteria.

Members may choose to receive CFC PAS only if they do not need or want CFC habilitation.

4122 Community First Choice Habilitation

Community First Choice (CFC) Habilitation assists members with acquisition, maintenance, and enhancement of skills necessary for the member to accomplish activities of daily living (ADLS), instrumental activities of daily living (IADLs), and health-related tasks. This service is provided to allow a member to reside successfully in a community setting by assisting the member to

acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the member on ADLs and IADLs. Personal assistance may be a component of CFC habilitation for some members. CFC habilitation services include training, which is interacting face-to-face with a member to train the member in activities, such as:

- self-care;
- personal hygiene;
- household tasks;
- mobility;
- money management;
- community integration, including how to get around in the community;
- use of adaptive equipment;
- personal decision-making;
- reduction of challenging behaviors to allow members to accomplish ADLs, IADLs, and health-related tasks; and
- self-administration of medication.

Information used to build a plan of care for CFC HAB may be found in the STAR Kids Screening and Assessment Instrument (SK-SAI) Personal Care Assessment Module (PCAM) in Section P. This section of the PCAM should only be administered if, after the assessor or service coordinator explains the CFC benefit and the member wishes to be assessed for CFC.4123 Choice Emergency Response

Community First Choice emergency response services (ERS) provides backup systems and supports to ensure continuity of services and supports. Reimbursement for backup systems and supports is limited to electronic devices to ensure continuity of services and supports and are available for members who live alone, who are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. A member must be cognitively able to recognize an emergency situation and be able to recognize the need to use ERS for ERS to be authorized.

Need for ERS is assessed using the STAR Kids Screening and Assessment Instrument, Section Z.

4124 Community First Choice Emergency Response Service

Community First Choice (CFC) emergency response service (ERS) is designed to assist individuals who do not require supervision during the day or are alone for large parts of the day, and are cognitively able to recognize an emergency. This service connects a member to an emergency response service provider who notifies local authorities, like paramedics or a fire department, to a member's emergency. This service is not routinely authorized for members who are minors.

4125 Community First Choice Support Management

Community First Choice (CFC) support management provides voluntary training on how to select, manage and dismiss attendants. Support management is available to any member receiving CFC services, regardless of their selected service delivery model.

Need for support management is assessed using the STAR Kids Screening and Assessment Instrument, Section Z.4130 Community First Choice Assessment and Authorization.

4131 Assessment for a Nursing Facility Level of Care

Nursing facility level of care for members seeking Community First Choice (CFC) services is established using the STAR Kids Screening and Assessment Instrument (SK-SAI). The managed care organization (MCO) must complete all "MN required" fields, as specified in the SK-SAI Document Map (see Appendix I, STAR Kids Project MCO Business Rules for SK-SAI and SK-ISP), particularly items contained in the Nursing Care Assessment Module (NCAM). These items will be used by a Texas Medicaid & Healthcare Partnership (TMHP) nurse to evaluate the member's eligibility for NF services according to Texas Administrative Code §19.2401 definition of “medical necessity”.

To ensure the TMHP evaluates the submitted SK-SAI for the nursing facility level of care, the MCO must submit the SK-SAI with field Z5a=1 to indicate that a medical necessity determination is needed. TMHP's determination will be communicated to the MCO on the substantive response file, as specified in Appendix I, STAR Kids Project MCO Business Rules for SK-SAI and SK-ISP.

If TMHP determines that the member does not meet medical necessity, the member is not eligible to receive CFC through the nursing facility level of care. This does not preclude the member or MCO from seeking determination of a different institutional level of care. If TMHP determines that that the member meets medical necessity and the functional assessment conducted by the MCO indicates a need for CFC services, the member is eligible to receive CFC through the nursing facility level of care.

4131.1 Reassessment for a Nursing Facility Level of Care

For members requiring a reassessment of medical necessity (MN) for a nursing facility level of care for continued eligibility for Community First Choice (CFC) services, the managed care organization (MCO) administers the entire STAR Kids Screening and Assessment Instrument (SK-SAI), including appropriate modules, no earlier than 90 days before or no later than 30 days prior to the expiration of the member’s current individual service. Plan (ISP) on file. The MCO must indicate yes in Field Z5a to notify Texas Medicaid & Healthcare Partnership (TMHP) that an MN determination is required. Form 2601, Physician Certification, is not required for reassessments of MN if the member's file contains the form for a previous assessment. The MCO must ensure that the reassessment is timed to prevent any lapse in service authorization.

4132 Assessment for an Intermediate Care Facility Level of Care

Described in Section 4111, Determining Institutional Level of Care, if the managed care organization (MCO) knows or believes a member has an intellectual disability or related condition, the MCO refers the member to their Local Intellectual and Developmental Disability Authority (LIDDA). The LIDDA and the MCO communicate during the assessment process through a Secure File Transfer Protocol (SFTP) Site, updating the file as the member moves through the assessment process. The MCO initiates a referral to the LIDDA by adding a referred member to the spreadsheet. The MCO must provide the member's named service coordinator and their contact information to assist in coordinating assessment activities. Following completion of the Determination of Intellectual Disability (DID) and Intellectual Disability/ Related

Condition Assessment (ID/RC), the LIDDA submits the assessment for a determination of level of care to the state. Health and Human Services Commission (HHSC) informs both the LIDDA and MCO of the determination. If a member is determined to not meet the level of care provided in an intermediate care facility, the MCO is responsible for notifying the member through their established denial process. HHSC attends the fair hearing if one if requested.

If a member meets an Intermediate Care Facility (ICF) level of care (LOC), the MCO follows the process outlined in Section 4140, Functional Assessment for Community First Choice Services to determine the member's service plan. When the member selects a service provider, the MCO updates the Secure File Transfer Protocol (SFTP) site noting the member's selected provider. If a member declines or discontinues CFC services the MCO must update the SFTP site noting the date the member declined or discontinued services.

4132.1 Reassessment for an Intermediate Care Facility Level of Care

Ninety (90) days prior to the expiration of the member's level of care assessment, the Local Intellectual and Development Disability Authority (LIDDA) updates the Secure File Transfer Protocol (SFTP) Site requesting the managed care organization (MCO) confirm the member requires a reassessment of an intermediate care facility level of care. If a member is receiving Community First Choice (CFC) services, the MCO indicates the member requires a reassessment. If the member declined or discontinued CFC services, the MCO indicates the member does not require a reassessment. The LIDDA and the MCO follow the processes outlined in Section 4132, Assessment for an Intermediate Care Facility Level of Care, for all reassessments.

If a member continues to meet an intermediate care facility level of care, the MCO follows the process outlined in Section 4140, Functional Assessment for Community First Choice Services to determine the member's service plan. When the member selects a service provider, the MCO updates the SFTP site noting the member's selected provider. If a member declines or discontinues CFC services the MCO must update the SFTP site noting the date the member declined or discontinued services.

4133 Assessment for an Institution Providing Psychiatric Services Level of Care

Described in Section 4111, Determining Institutional Level of Care, if the managed care organization (MCO) knows or believes a member has serious emotional disturbance (SED) or serious and persistent mental illness (SPMI), the MCO refers the member to their Local Mental Health Authority (LMHA) or to a comprehensive provider of mental health rehabilitative services. This provider conducts the Child and Adolescent Needs (CANS) or Strengths or Adult Needs and Strengths Assessment (ANSA), depending on the member's age. Based on an algorithm, the assessment determines the member's level of care (LOC). A licensed practitioner must concur with the assessment or may provide deviate a member to a higher or lower LOC, based on their clinical judgement. A licensed practitioner must review the CANS or ANSA at least annually. Mental health rehabilitative services are reassessed more frequently than the level of care for Community First Choice (CFC) services. For the purposes of eligibility for CFC services, a member's CANS or ANSA is valid for 12 months.

Members enrolled in the Youth Empowerment Services (YES) waiver meet a psychiatric institutional level of care and do not require an additional assessment of level of care to receive

Community First Choice (CFC) services. These members may be assessed by their health plan for functional necessity of CFC services at any time while enrolled in YES.

4133.1 Reassessment for an Institute for Mental Disease Level of Care

Assessment of a psychiatric institutional level of care must be reassessed annually for continued eligibility for Community First Choice (CFC) services. 60 days prior to the expiration of the member's CFC service plan, the managed care organization (MCO) must refer the member to their Local Mental Health Authority (LMHA) or to a comprehensive provider to mental health rehabilitative services. This provider conducts the Child and Adolescent Needs (CANS) or Strengths or Adult Needs and Strengths Assessment (ANSA), which must be reviewed by a licensed practitioner to determine if the member continues to meet a psychiatric institutional level of care. If the member continues to meet this level of care (LOC), the MCO conducts the CFC functional assessment.

If the member does not meet a psychiatric institutional level of care, the MCO may conduct the STAR Kids Screening and Assessment Instrument (SK-SAI) to determine if the member meets medical necessity for a nursing facility level of care. If the MCO believes the member will not meet medical necessity and does not have an intellectual or developmental disability, the MCO must notify the member or their representative of the denial for CFC services. The member may be eligible for personal care services (PCS), if functionally necessary.

4140 Functional Assessment for Community First Choice Services

Functional need for Community First Choice (CFC) services is primarily established by Sections J, K, L, M, N, O, and P of the STAR Kids Screening and Assessment Instrument (SK-SAI) which form the Personal Care Assessment Module (PCAM). This module contains assessment questions for the attendant care (CFC PAS) and habilitation services available through CFC. The following questions in the SK-SAI Core Module are triggers for the PCAM and may indicate the member has functional need for CFC services:

- A personal care aide is provided in a school or day program;
- The caregiver, member, or others are concerned about the member's developmental status or decline from baseline related to self-care (dressing, bathing, using toilet self-care);
- Decline in functional status as compared to 90 days ago or since last assessment;
- Instrumental activity of daily living (IDAL) self-performance;
- Activity of daily living (ADL) self-performance;
- The member is moderately or severely impaired regarding cognitive skills for daily decision making;
- The member requires diet modification to swallow solid food;
- The member requires modifications to swallow liquids;
- The member received personal care services, attendant care, or a home health aide in the last 30 days; and/or
- The member or their legally authorized representative requests an assessment for Community First Choice (CFC) or personal care services (PCS).

If triggered, the service coordinator completes the PCAM (sections J, K, L, M, N, O, and P) to determine attendant care needs. Section P should only be completed if the member is

specifically seeking CFC services. The service coordinator also completes SK-SAI Section Y, Worksheets, to assist in developing a recommended number of hours. Based on the assessment, the service coordinator develops a recommended service plan for the delivery of CFC services. The service coordinator works with the member or their representative to locate an appropriate provider and sends an authorization to the selected provider.

4140.1 Reassessment of Functional Need for Community First Choice

The need for and the amount and duration of Community First Choice (CFC) services must be reassessed every 12 months, or when requested due to a change in the member's health condition or living situation.

4150

Reserved

4200 Personal Care Services

Personal care services (PCS) are a benefit under the Early and Periodic Screening, Diagnosis, and Treatment Comprehensive Care Program, known in Texas as the Texas Health Steps Comprehensive Care Program (THSteps-CCP). PCS is available to STAR Kids members from birth through age 20. PCS is considered medically necessary when a member requires assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health maintenance activities (HMAs) because of physical, cognitive, or behavioral limitations related to the member's disability or chronic health condition. The member's disability or chronic health condition must be substantiated by a physician statement of need (PSON).

By their nature, and as defined by law, the scope of ADLs, IADLs, and HMAs includes a range of activities that healthy, nondisabled adults can perform for themselves. Developing children gradually and sequentially acquire the ability to perform these ADLs and IADLs for themselves. PCS does not include ADL, IADL, or HMA activities that a typically developing child of the same chronological age would not be able to safely and independently perform without adult supervision. As required by law, a member's responsible adult must perform ADLs, IADLs, and HMAs on behalf of the client to the extent that the need to do so would exist in a typically developing child of the same chronological age. Medicaid PCS benefits are limited to situations where the need for assistance to perform the ADLs, IADLs, and HMAs is caused by the member's physical, cognitive, or behavioral limitation related to the client’s disability or chronic health condition. PCS include direct intervention to assist the client in performing a task or indirect intervention by cueing the client to perform a task.

Clients must have a medical or cognitive need for specific tasks. PCS are medically necessary only when a client has a physical, cognitive, or behavioral limitation related to the client’s disability or chronic health condition that inhibits the client’s ability to accomplish ADLs, IADLs, or HMAs.
PCS includes:

- Assistance with ADLs and IADLs;
- Nurse-delegated tasks and Health Maintenance Activities (HMAs) within the scope of PCS, as permitted by program policy and 22 TAC Chapter 225 (relating to RN

Delegation to Unlicensed Personnel and Tasks not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions); and
- Hands-on assistance, cueing, redirecting, or intervening, to accomplish the approved PCS task.

The amount and duration of PCS is determined by the managed care organization (MCO) and must take the following into account:

- Whether the member has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition that inhibits the member's ability to accomplish ADLs or IADLs;
- The member's caregiver's need to sleep, work, attend school, and meet their own medical needs;
- The member's caregiver's legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of their other members of the household;
- The member's caregiver's physical ability to perform the PCS;
- Whether requiring the member's caregiver's to perform the PCS will put the member's health or safety in jeopardy;
- The time periods during which the PCS tasks are required by the member, as they occur over the course of a 24-hour day, and a 7-day week;
- Whether or not the need to assist the family in performing PCS on behalf of the member is related to a medical, cognitive, or behavioral condition that results in a level of functional ability that is below that expected of a typically developing child of the same chronological age; and
- Whether services are needed based on:
    - the physician's statement of need; and
    - the assessment for personal care described in Section 4210, Assessment for Personal Care.

PCS may be authorized to support a member's primary caregiver(s) but may not be authorized to supplant a member's natural support, nor to provide a member's total care. PCS may be authorized in an individual or group setting including, but not limited to:

- The member's home;
- The home of the primary or other care giver;
- The member's school;
- The member's day care facility; or
- Any community setting in which the member is located.

The MCO must not reimburse PCS that duplicate services that are the legal responsibility of the school districts. The school district, through the School Health and Related Services (SHARS) program is required to meet the member's personal care needs while the member is at school. However, if those needs cannot be met by SHARS or the school district, documentation may be submitted to the MCO with documentation of medical necessity (MN).

PCS may not be authorized in a hospital, nursing facility (NF), institution providing psychiatric care, or an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IDD).

PCS may not be used as respite, child care, or for the purposes of restraining a member. PCS may be authorized in a group setting.

A member may not be authorized to receive both PCS and Community First Choice (CFC) services at the same time.

Members who receive services through the following 1915(c) waiver programs receive CFC services through their waiver program and are not eligible to receive PCS through the MCO:

- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS)
- Texas Home Living (TxHmL)

4210 Assessment for Personal Care Services

Sections J, K, L, and M of the STAR Kids Screening and Assessment Instrument (SK-SAI) form the Personal Care Assessment Module (PCAM). This module contains assessment questions for personal care services (PCS). The following questions in the SK-SAI Core Module are triggers for the PCAM and may indicate the member requires PCS:

- A personal care aide is provided in a school or day program;
- The caregiver, member, or others are concerned about the member's developmental status or decline from baseline related to self-care (dressing, bathing, using toilet self-care);
- Decline in functional status as compared to 90 days ago or since last assessment;
- Instrumental activity of daily living (IADL) self-performance;
- Activity of daily living (ADL)self-performance;
- The member is moderately or severely impaired regarding cognitive skills for daily decision making;
- The member requires diet modification to swallow solid food;
- The member requires modifications to swallow liquids;
- The member received PCS, attendant care, or a home health aide in the last 30 days; and/or
- The member or their legally authorized representative requests an assessment for Community First Choice or PCS.

If triggered, the service coordinator completes the PCAM (sections J, K, L, M, N, and O) to determine attendant care needs. Section P should not be completed if the member is only seeking PCS and not CFC. The service coordinator also completes SK-SAI Section Y, Worksheets, to assist in developing a recommended number of hours. Based on the assessment, the service coordinator develops a recommended service plan for the delivery of PCS. The service coordinator works with the member or their representative to locate an appropriate provider and sends an authorization to the selected provider.

4211 Reassessment for Personal Care Service

The need for and the amount and duration of personal care services (PCS) must be reassessed every 12 months, or when requested due to a change in the member's health or living condition.

The managed care organization (MCO) must obtain a new physician statement of need to substantiate the member's continued need for PCS upon each annual reassessment.

4220 Personal Care Services Providers

Personal care services (PCS) must be provided by an individual who:

- is 18 years of age or older;
- is an attendant who;
    - is an employee of a provider organization licensed as a home and community support services agency (HCSSA), or organizations licensed to provide home health services or personal assistance services; or
    - is employed by the member or their legally authorized representative (LAR) through the consumer directed services (CDS) option.
- has demonstrated the competence necessary, when competence cannot be demonstrated through education and experience, to perform the personal assistance tasks assigned by the HCSSA or by the member or the member's responsible adult or LAR acting as employer through the CDS option.
- is not the responsible adult of the member if the member is under the age of 18; and
- is not the spouse of the member.

4300 Private Duty Nursing

Private duty nursing (PDN) is a benefit under the Early and Periodic Screening, Diagnosis, and Treatment Comprehensive Care Program, known in Texas as the Texas Health Steps Comprehensive Care Program (THSteps-CCP). PDN is available to STAR Kids members from birth through age 20. PDN services must be available when the services are medically necessary to correct or ameliorate a member's disability or physical or mental illness or condition. The services correct or ameliorate when they improve, maintain, or slow the deterioration of the member's health status.

Nursing services are medically necessary under the following conditions:

- The services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations;
- The services correct or ameliorate the member's disability, physical or mental illness, or condition. Nursing services correct or ameliorate the member's disability, physical or mental illness, or condition when the services improve, maintain, or slow the deterioration of the member's heath status.
- There is no third party resource (TPR) financially responsible for the services.

PDN should prevent prolonged and frequent hospitalizations or institutionalization and provide cost effective and quality care in the most appropriate, least restrictive environment. PDN provides direct nursing care and caregiver training and education. The training and education is intended to optimize member health status and outcomes, and to promote family-centered, community-based care as a component of an array of service options.

PDN is considered only when the services are consistent with the definition of "nursing" as described in the Texas Nursing Practice Act or its implementing regulations. PDN services must not be considered for reimbursement if the services are intended solely to provide respite care or child care, or do not directly relate to the member's nursing needs.

The managed care organization (MCO) may deny or reduce PDN hours if the member's PDN needs decrease. The MCO may not:

- deny or reduce PDN when the member's nursing needs have not decreased;
- require a member's responsible adult(s) to provide PDN services to the member;
- require a member or a member's responsible adult(s) to designate an alternate caregiver to provide PDN services; or
- deny or reduce the amount of authorized PDN services because the member's responsible adult(s) is trained and capable of performing such services, but chooses not to do so.

4310 Assessment for Private Duty Nursing

Section Q forms the Nursing Care Assessment Module (NCAM) of the STAR Kids Screening and Assessment Instrument (SK-SAI) and contains assessment questions for private duty nursing (PDN). The following questions in the SK-SAI Core Module are triggers for the NCAM and may indicate the member requires PDN:

- A skilled nursing visit or private duty nursing is provided in a school or day program;
- The member experienced one or more planned or unplanned inpatient acute hospital admissions or a nursing home stay in the past year;
- The member requires enteral or parenteral feeding;
- The member received any of the following treatments in the last 30 days:
    - Chemotherapy;
    - Dialysis;
    - Intravenous (IV) medication;
    - Oxygen therapy;
    - Radiation;
    - Suctioning;
    - Tracheotomy care;
    - Transfusion;
    - Ventilator;
    - Wound care;
    - Nebulizer;
    - Urinary catheter care –insertion or maintenance;
    - Comatose or persistent vegetative state – manage care';
    - Continuous positive airway pressure (CPAP) or Bi-level Positive Airway Pressure (BiPAP);
    - Chest percussive therapy;
    - Active medication adjustment;
    - IPPB; and/or
    - Seizure Management;

- The member is being assessed for Community First Choice (CFC) services or the Medically Dependent Children Program (MDCP).

If triggered, the service coordinator completes the NCAM addendum (Section Q) to determine the member's nursing needs. The service coordinator also completes SK-SAI Section Y, Worksheets, to assist in developing a recommended number of hours. Based on the assessment, the service coordinator develops a recommended service plan for the delivery of PDN. The service coordinator works with the member or their representative to locate an appropriate provider and sends an authorization to the selected provider.

4311 Reassessment and Reauthorization

At a minimum, the need for and the amount and duration of private duty nursing must be reassessed 90 days following initial authorization and every 6 months, or when requested due to a change in the member's health or living condition. A physician order must be renewed with any reassessment.

4320 Providers of Private Duty Nursing

Private duty nursing (PDN) may be provided by a licensed home and community support services agency (HCSSA), an independently enrolled registered nurse (RN) or a licensed vocational nurse (LVN) under the supervision of an RN, contracted with the STAR Kids managed care organization (MCO).

An RN must develop a plan of care that accounts for the following items, at a minimum:

- a clinical summary that documents active diagnoses and current clinical condition;
- the member's mental or cognitive status;
- the types of treatments and services, including amount, duration, and frequency;
- a description of any required equipment and/or supplies;
- the member's prognosis;
- the member's rehabilitation potential;
- the member's current functional limitations;
- the activities permitted;
- the member's nutritional requirements;
- the member's medications, including dose, route, and frequency;
- the safety measures to protect against injury;
- instructions for timely discharge or referral;
- the date the member was last seen by the treating physician;
- identification of activities of daily living and health maintenance activities with which the member needs assistance. The plan of care must indicate whether the tasks must be performed by a licensed nurse or a qualified aide, or may be performed by a personal care attendant;
- a certification statement that an identified contingency plan exists; and
- all other medical orders.

PDN must not be provided by a member's legally responsible adult if the member is under 18 or the spouse of the member.

4330 Private Duty Nursing and Prescribed Pediatric Extended Care Center Services

Private duty nursing (PDN) services and nursing services provided through a Prescribed Pediatric Extended Care Center (PPECC), as described in Section 4400, are considered to be an equivalent level of nursing care; a client who qualifies for PDN will qualify for PPECC.

A client has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. Members must be informed of their service options for ongoing skilled nursing (PDN or PPECC), when PPECC services are available in the service delivery area. A member may receive both PDN and PPECC on the same day, but not at the same time. (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the client's medical condition or the authorized hours are not commensurate with the client's medical needs. Per §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

Because the total number of approved skilled nursing hours do not decrease, HHSC views a shift from PDN to PPECC as a provider change, and not an adverse action. The fee-for-service Nursing Addendum to Plan of Care for Prescribed Pediatric Extended Care Centers and Private Duty Nursing includes updated client acknowledgements, including an acknowledgement that PDN hours may decrease if they shift their hours to the PPECC, or vice versa.

Achieving a one-to-one replacement of existing PDN hours with PPECC (or vice versa) to prevent service duplication will require an examination of authorizations for both PDN and PPECC services, including a review of the 24-hour flow sheet for nursing care. For example, when a client with PDN decides to shift hours to a PPECC, then the PDN authorized hours will be decreased by the amount of hours shifted to a PPECC, unless there is a change in the Member's medical condition requiring additional hours, or the authorized hours are not commensurate with the client's medical needs. The PDN provider would be notified by the MCO of the revised (decreased) authorized hours. The PDN provider may submit a revision request with documentation to justify medical necessity for any additional hours requested. The PPECC and PDN providers are expected to coordinate on their respective plan of care for the member. The Service Coordinator is expected to play a role in ensuring the coordination between PPECC and PDN service providers and authorized services.

4400 Prescribed Pediatric Extended Care Centers

Prescribed Pediatric Extended Care Center (PPECC) services may be a benefit of the Texas Health Steps Comprehensive Care Program (THSteps-CCP) for STAR Kids members who meet the following medical necessity criteria for admission:

- eligible for THSteps-CCP;
- age 20 years or younger;
- have an acute or chronic condition that requires ongoing skilled nursing care and supervision, skillful observations, judgments and therapeutic interventions all or part of the day to correct or ameliorate health status;
- considered to be a medically dependent or technologically dependent member

- stable for outpatient medical services, and does not present significant risk to other individuals or personnel at the PPECC;
- requires ongoing and frequent skilled interventions to maintain or ameliorate health
- status, and delayed skilled intervention is expected to result in:
    - deterioration of a chronic condition;
    - loss of function;
    - imminent risk to health status due to medical fragility; or
    - risk of death.
- has a prescription for PPECC services signed and dated by an ordering physician who has personally examined the member within 30 calendar days prior to admission and reviewed all appropriate medical records; has consent for the member's admission to the PPECC signed and dated by the member or the member's responsible adult. Admission must be voluntary and based on the preference for PPECC services in place of PDN by the member or member's responsible adult in both managed care and non-managed care service delivery systems.
- resides with the responsible adult and does not reside in any 24-hour inpatient facility, including a general acute hospital, skilled nursing facility, intermediate care facility (ICF), or special care facility.

PPECC services require prior authorization, and are intended as an alternative to private duty nursing (PDN). However, an admission authorized under this section is not intended to supplant the right of a member to access PDN, personal care services (PCS), home health skilled nursing (HHSN), home health aide (HHA), and therapies (PT, OT, ST), as well as respiratory therapy and early childhood intervention (ECI) services rendered in the member's residence when medically necessary.

NOTE: PPECC services may be billed on the same day as PDN, Personal Care Services, Home Health Skilled Nursing, and Home Health Aide Services, but PPECC services must not be billed for the same span of time a member receives these other services.

A member who is eligible may receive both private duty nursing and PPECC services. PPECC benefits include the following services:

- The development, implementation, and monitoring of a comprehensive plan of care that:
    - is provided to a medically dependent or technologically dependent member;
    - is developed in conjunction with the member’s caregiver(s), ordering physician, and interdisciplinary team;
    - specifies the services needed to address the medical, nursing, psychosocial, therapeutic, dietary, functional, and developmental needs of the member and the training needs of the member’s caregiver(s);
    - specifies if transportation to and from the PPECC is needed; and
    - is revised for each authorization of services or more frequently as the ordering physician deems necessary.
- Direct skilled nursing care and caregiver training and education intended to:
    - optimize the member’s health status and outcomes; and
    - promote and support family-centered, community-based care as a component of an array of service options by:
        - preventing prolonged or frequent hospitalizations or institutionalization;
        - providing cost-effective, quality care in the most appropriate environment; and

        - providing training and education of caregivers.
- Nutritional counseling and dietary services as specified in a member's plan of care.
- Assistance with activities of daily living while the member is in the PPECC;
- Psychosocial and functional development services, and
  Transportation services to and from a PPECC. Transportation must be provided by a PPECC when a member has a stated need or a prescription for transportation to the PPECC. When a PPECC provides transportation to a member, a nurse employed by the PPECC must be on board the transport vehicle. The member must be able to utilize transportation services offered by the PPECC with the assistance of a PPECC nurse to and from the PPECC, rather than a non-emergency ambulance. Transportation is billed separately by the PPECC when utilized by a member. A non-emergency ambulance may not be utilized for transport to and from a PPECC.

NOTE: A member or the member's responsible adult may decline a PPECC's transportation, and choose to be transported by other means, including his or her responsible adult. A member's legally authorized representative is not required to accompany a member when the member receives services in a PPECC, including transportation services to and from the center and therapy services that are billed separately. Fee-for-service Medicaid does not require prior authorization for the transportation billing code. Rather, authorization for PPECC services implies authorization for transportation.

PPECC services do not include services that are mainly respite care or child care, or that do not directly relate to the member's medical needs or disability, nor for services that are the primary responsibility of a local school district. PPECC services also do not include baby food or formula, services to members that are related to the PPECC owner by blood, marriage or adoption, services covered separately by Texas Medicaid, such as therapies or durable medical equipment, or individualized comprehensive case management beyond that required for service coordination.

4410 Assessment for Prescribed Pediatric Extended Care

Section Q forms the Nursing Care Assessment Module (NCAM) of the STAR Kids Screening and Assessment Instrument (SK-SAI) and contains assessment questions for services in a Prescribed Pediatric Extended Care Center (PPECC). The following questions in the SK-SAI Core Module are triggers for the NCAM and may indicate the member requires ongoing nursing services:

- A current authorization for private duty nursing
- A skilled nursing visit or private duty nursing is provided in a school or day program;
- The member experienced one or more planned or unplanned inpatient acute hospital admissions or a nursing home stay in the past year;
- The member requires enteral or parenteral feeding;
- The member received any of the following treatments in the last 30 days:
    - Chemotherapy;
    - Dialysis;
    - Intravenous (IV) medication;
    - Oxygen therapy;
    - Radiation;
    - Suctioning;

    - Tracheotomy care;
    - Transfusion;
    - Ventilator;
    - Wound care;
    - Nebulizer;
    - Urinary catheter care –insertion or maintenance;
    - Comatose or persistent vegetative state – manage care'
    - Continuous positive airway pressure (CPAP) or Bi-level Positive Airway Pressure (BiPAP);
    - Chest percussive therapy;
    - Active medication adjustment;
    - IPPB; and/or
    - Seizure Management;
- The member is being assessed for Community First Choice (CFC) services or the Medically Dependent Children Program (MDCP).

If triggered, the service coordinator completes the NCAM addendum (Section Q) to determine the member's nursing needs. The service coordinator also completes SK-SAI Section Y, Worksheets, to assist in developing a recommended number of hours. Based on the assessment, the service coordinator develops a recommended service plan for the services of a PPECC. The service coordinator works with the member or their representative to locate an appropriate provider and sends an authorization to the selected provider.

NOTE: If a client qualifies for PDN, the client will qualify for PPECC.

4411 Reassessment and Reauthorization

At a minimum, the need for and the amount and duration of services from a Prescribed Pediatric Extended Care Center must be reassessed 90 days following initial authorization and every 180 days s following, or when requested due to a change in the member's health or living condition. A physician order must be renewed with any reassessment.

4420 Providers of Prescribed Pediatric Extended Care

A Prescribed Pediatric Extended Care Center (PPECC) must be currently licensed (temporary, initial, or renewal license), comply with 40 TAC Chapter 15 (relating to Licensing Standards for Prescribed Pediatric Extended Care Centers), and be contracted with a member’s STAR Kids managed care organization (MCO) to provide services to that member. Contractual provisions for continuity of care apply A PPECC does not provide emergency services. PPECCs must follow the safety provisions in state PPECC licensure requirements, including the adoption and enforcement of policies and procedures for a member’s medical emergency. PPECCs must call for emergency transport to the nearest hospital when emergency services are needed by a member in a PPECC. Per PPECC licensure requirements, services are non-residential, must be included in a PPECC plan of care (POC), and are limited to no more than 12 hours in a 24-hour period. Services may not be rendered overnight (9:00 PM to 5:00 AM).

A POC must include components as detailed in the Texas Medicaid Provider Procedure Manual and PPECC Medical Policy. These components include:

- The Member's name, date of birth and Medicaid number;

- The PPECC's name, TPI, NPI, and hours of operation, as well as address, phone, and fax numbers;
- The ordering physician's name, phone number, TPI and NPI;
- Date the PPECC nursing assessment was completed and name, title, and credentials of the RN who completed the POC and his/her dated signature;
- Name, title and credentials of the team member who completed the POC and his/her dated signature;
- Date the Member was last seen by the ordering physician;
- The requested start of care date for PPECC services;
- All pertinent diagnoses and known allergies;
- Nursing services to be provided, including amount, duration, and frequency;
- Member's prognosis;
- Member's mental status;
- Rehabilitation potential
- Equipment and/or supplies required;
- Therapies (occupational, physical, speech, and respiratory care), including how those therapies are accessed, amount, duration, and frequency. Therapies provided in the PPECC, as well as outside the PPECC (e.g., school based), must be documented.
- Other prescribed services, including amount, duration, and frequency;
- Nutritional requirements, including type, method of administration, and frequency;
- Medications, including the dose, route, frequency and any medication-related allergies if known;
- Treatments, including amount and frequency;
- Wound care orders and measurements;
- Safety measures to protect against injury;
- Functional developmental services and psychosocial services, including amount, duration and frequency;
- Name, phone number and signature of responsible adult;
- Client emergency contact name and phone number;
- Confirmation that a signed contingency plan is in place in circumstances when PPECC services are not available (e.g., fire, flood, windstorm, or electrical malfunctions), and for emergencies that occur while the client is in the care of the PPECC;
- List of services the client receives in the home and school settings. (e.g., ECI, therapies, school-based services (SHARS), PCS, PDN, therapies, skilled home health, case management services, hospice, and Medicaid waiver programs such as Medically Dependent Children's Program (MDCP), Home and Community-Based Services (HCS), Deaf-Blind Multiples Disabilities (DBMD), Texas Home Living (TxHmL), and Community Living Assistance and Support Services (CLASS)).

NOTE: Services provided under these programs will not prevent a client from obtaining medically necessary services.

- Client-specific measureable goals, including, if receiving PDN, the goal of ensuring coordination of ongoing skilled nursing services with the PDN provider, if receiving PDN;
- Responsible adult training needs;
- Prior and current functional or medical limitations;

- Permitted activities;
- Client's scheduled days and hours of attendance;
- Confirmation of a discharge plan, including instructions for timely discharge or referral;
- Emergency contact information;
- Method of transportation;
- Private Duty Nursing provider name, TPI, NPI, phone, address and fax number, if known; and
- Ordering physician signature and date of signature.
- Transportation services needed by a member to access PPECC services.
    - A non-emergency ambulance may not be utilized for transport to and from a PPECC.
- Services outlined in the Texas Administrative Code, Title 1, Part 15, Chapter 636 (Texas Health Steps Comprehensive Care Program), Subchapter B (Prescribed Pediatric Extended Care Center Services), Rule §363.211 (Benefits and Limitations)

A face-to-face evaluation must be performed annually by the ordering physician. A physician order is required for each initial and recertificationauthorization, and revisions. A physician in a relationship with a PPECC (employed by or contracted with a PPECC) cannot provide the physician's order, unless the physician is the member's treating physician and has examined the member outside of the PPECC setting. The following services may be rendered at a PPECC place of service, but are not considered part of the PPECC services and must be billed separately by a provider contracted with the STAR Kids managed care organization (MCO):

- Speech, physical, and occupational therapies (including therapies rendered by a home health agency)
- Certified respiratory care services
- Early intervention services provided through the Early Childhood Intervention (ECI) program, which are subject to ECI policies.

Authorization requirements

Per §363.211, initial, recertification and revision requests for PPECC services must include the following documentation, which adheres to requirements in the Texas Medicaid Provider Procedures Manual:

(1) physician order for services (a physician signature on the PPECC plan of care serves as a physician order for authorization purposes);

(2) a plan of care developed by the PPECC;

(3) all required prior authorization forms listed in the Texas Medicaid Provider Procedures Manual, or MCO forms if they contain comparable content; and

(4) signed consent of the participant or participant's responsible adult documenting the choice of PPECC services. The signed consent must include an acknowledgement by the participant or the participant's responsible adult that he or she has been informed that other services such as private duty nursing might be reduced as a result of accepting PPECC services. Consent to share the participant's personal health information with the participant's other providers, as needed to ensure coordination of care, must also be obtained.

Forms available online for PPECC include:

- CCP Prior Authorization Request form (requires ordering physician signature)
- Prescribed Pediatric Extended Care Center (PPECC) Plan of Care (POC) (requires ordering physician, PPECC RN and Member/Responsible adult signature)

NOTE: Providers may use their own POC form, but it must contain the required elements per the Texas Medicaid Provider Procedures Manual.

- Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form (requires ordering physician, PPECC RN, and Member/Responsible adult signature) This form contains required client and physician acknowledgements and consent.

When an MCO decides to use their own forms for PPECC authorizations, the forms must be equivalent to the fee-for-service forms, and are subject to approval by HHSC.

4430 PDN and Prescribed Pediatric Extended Care Center Services

See 4330 for details on coordination of services between Private Duty Nursing and Prescribed Pediatric Extended Care Center Services. Both are PDN and PPECC are ongoing skilled nursing services, and are considered equivalent levels of nursing care. A member has a choice to receive PDN, PPECC, or a combination of both services. 4500 Day Activity and Health Services

Day Activity and Health Services (DAHS), also called adult day care, is a Medicaid state plan service available to STAR Kids members ages 18 and older who require the service because of a chronic medical condition and are able to benefit therapeutically from the service. DAHS provides attendant care in a facility setting, under the supervision of a nurse. Services include nursing, physical rehabilitation, nutrition, social activities, and transportation when another means of transportation is unavailable.

4510 Assessment for Day Activity and Health Services

The potential for therapeutic benefit must be established by a physician's assessment and requires a physician's order.

A Day Activity and Health Services (DAHS) facility nurse must complete a health assessment for each STAR Kids member at the facility. The assessment may be conducted by a registered or licensed vocational nurse, based upon the member's condition at the time of initial assessment. The DAHS facility nurse completes a health assessment at either the facility or the member's home. Health assessments must be conducted, at minimum, when:

- members need initial assessment for prior authorization by a STAR Kids managed care organization;
- members transfer to a new facility (conducted by the new facility);
- at reauthorization;
- the DAHS nurse determines a member needs to be reassessed.

The member or their legally authorized representative (LAR) must sign the health assessment each time the nurse completes or revises the form. The health assessment must identify specific conditions that may affect a member's functioning.

4511 Reassessment for Day Activity and Health Services

Reassessment by a physician is required at least every 12 months for continued authorization. For this service, a physician assessment may be no older than 90 days from the date at which an authorization is requested.

A member is reassessed at regular intervals by the facility nurse. In addition the facility nurse assesses the member for nursing, physical rehabilitation, and nutritional services when:

- a member first enters the facility;
- transferring from another Day Activity and Health Services facility (DAHS)
- a member's condition changes. If the change in condition necessitates, the facility nurse coordinates with the member's service coordinator or physician for a physician assessment.

4520 Day Activity and Health Services Providers

To provide Day Activity and Health Services (DAHS), a facility must hold a current license from the Department of Aging and Disability Services, and comply with Texas Administrative Code, Title 40, Part 1, Chapter 98: Adult Day Care and Day Activity and Health Services Requirements.

DAHS facilities are responsible for:

- Nursing services
    - Nursing services include a member’s nursing assessment, assistance with prescribed medications, counseling concerning health needs and supervision of personal care services (PCS).
- Physical rehabilitative services
    - Physical rehabilitative services include restorative nursing and group and individual exercises, including range of motion exercises.
- Nutrition services, include:
    - one hot noon meal a day;
    - a mid-morning and mid-afternoon snack;
    - preparation of foods required for special diets; and
    - dietary counseling and nutrition education for the individual and his family.
- Transportation
    - Including to and from the facility, to and from the facility on an activity outing, and to and from a facility approved to provide therapies if the member requires specialized services on days of attendance at the DAHS facility. The provider must:
        - coordinate the use of other transportation resources within the community;
        - make every effort to have families transport individuals;

        - manage upkeep and operation of facility vehicles, including liability insurance. Vehicles used by the facility must be maintained in a condition to meet the vehicle inspection requirements of the Texas Department of Public Safety; and
        - have sufficient staff to ensure the safety of members being transported to and from their homes.
- Activities and other supportive services
    - Activities offered at the facility must be meaningful, fun, therapeutic, and educational.
    - A provider must offer at least three different scheduled activities in at least one or more of the following activities:
        - Exercise
        - Games;
        - Educational or reality orientation; and/or
        - Crafts.
    - A provider must offer at least one of the following activities, at cost to the provider, monthly:
        - Trips or special events, or
        - Cultural enrichment.

4600 Medically Dependent Children Program Services

Medically Dependent Children Program (MDCP) provides respite, flexible family support services, minor home modifications, adaptive aids, transition assistance services, supported employment, and employment assistance to prevent placement of individuals in long-term care facilities who are medically dependent and under 21 years of age and support deinstitutionalization of nursing facility residents under 21 years of age.

Only members who are assessed as meeting medical necessity (MN) and who have a slot in the MDCP waiver are eligible for MDCP services. Federal guidelines require that members must need and use one or more waiver services to qualify and maintain eligibility for MDCP. All members must have a need for and use MDCP services on a monthly basis to qualify for MDCP. The MCO service coordinator must inform all members receiving MDCP services that, at a minimum, one MDCP service must be used at least once a month to qualify and maintain enrollment in MDCP.

If a member is offered enrollment in MDCP or at an MDCP member's reassessment, during the STAR Kids assessment using the Screening and Assessment Instrument (SK-SAI), the service coordinator may discuss the member's needs as they relate to the available MDCP services. The service coordinator may develop a recommended individual service plan (ISP) if the member's resource utilization group (RUG) is not known, as the RUG determines the member's budget.

Example: The service coordinator could ask the member and/or their caregiver if they would like respite or the desire for employment services. The service coordinator could ask if the member requires adaptive aids, minor home modifications, or could benefit from flexible family support services. The service coordinator could inquire as the member and/or caregiver which services they would like more of, should the member's budget be unknown during the

assessment. Based on their discussion, the service coordinator could develop a recommended ISP for that member and work with the member and/or their caregiver in person or telephonically to develop a final service plan once the member's budget is known.

4700 Medically Dependent Children Program Respite and Flexible Family Support Services

4710 Medically Dependent Children Program Respite

Respite is a service that provides temporary relief from caregiving to the applicant/member or their primary caregiver during the times when the primary caregiver would normally provide care. The primary caregiver may be the applicant's/member's parent(s), guardian, a family member or spouse, if married.

In-home respite may be delivered by a Home and Community Support Service Agency (HCSSA), also called a home health agency, or through the Consumer Directed Services (CDS) option. Respite may be delivered by attendants or nurses employed through the CDS option. In-home respite is not limited to the individual’s place of residence. Respite may also be provided in other community settings when the situation does not exceed the limitations documented in Section 4720, Respite Service Limits. Other community settings could include the park, the respite provider’s home, or a home of the member's relative. Out-of-Home Respite may be provided in a facility setting, such as a nursing facility or hospital, or in a camp setting.

Respite is intended to provide relief to the primary caregiver, it may only be provided when a member's primary caregiver would normally provide the member's care. Respite may not be delivered while the member is in school or in a school setting. Respite must not be provided at the same time a duplicative service, such as Community First Choice (CFC) or private duty nursing (PDN). Duplication occurs when Medically Dependent Children Program (MDCP) respite provided by a nurse is rendered at the same time as another in-home nursing services (such as PDN) or when MDCP respite provided by an attendant is rendered at the same time as another attendant care service (such as CFC). Because respite is a service to provide relief to the primary caregiver, if the caregiver would normally be providing services, respite may be authorized at the same time. For example, nurse providing PDN is in the member's home for the purpose of suctioning, monitoring vitals, etc., and an MDCP respite attendant is in the home at the same time providing CFC to the member to relieve the caregiver of tasks they would normally be responsible for performing. Circumstances which require two personnel for a two-person transfer are not considered a duplication of services. In that scenario, the private duty nurse and MDCP respite attendant could collaborate to accomplish the transfer.

STAR Kids managed care organizations (MCOs) may determine the number of units of respite to authorize for an MDCP member based on the member and/or legally authorized representative's (LAR) preferences and the member's approved cost limit. MCOs must develop internal processes related to respite service schedules, schedule changes, and policies regarding setting aside funds within individual service plan (ISP). MCOs must develop a process to allow for flexible schedules and allow an MDCP member to "bank" respite hours to use at later point in the ISP year. The MCO must document banked hours using Form 2605, Respite Tracking Tool.

4711 In-Home Respite

In-home respite is not limited to the individual's place of residence. Respite may also be provided in other community settings, which could include the park, the respite provider's home, or a home of the individual's relative. In-home respite may be provided by a licensed home and community support services agency (HCSSA), also called a home health agency, or the provider employed by a member or their legally authorized representative (LAR) under the consumer directed services (CDS) option.

A member's in-home respite is limited by the amount of the member's cost limit. If the member chooses the CDS option, the member is limited by their available budget. MCOs may have additional policies and procedures regarding reserving capacity in a member's budget. The provision of in-home respite is documented on the individual service plan.

4711.1 Attendant with Delegated Tasks

A delegated task is defined as a task that a practitioner or registered nurse (RN) delegates in accordance with state law. In general, the Texas Board of Nursing (BON) defines nurse delegation as authorizing an unlicensed person to provide nursing services while retaining accountability for how the unlicensed person performs the task. In brief, the Texas Occupations Code indicates a physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate. Only RN may delegate to an attendant under their supervision, per BON rules. A member with a skilled task need may use an attendant with delegated tasks if a practitioner or RN delegates the skilled task required to meet the member's needs.

If the member does not have a skilled task need for the delivery of respite, he or she does not have a need for an attendant with delegated tasks. If the member or primary caregiver requests the use of an attendant with delegated tasks, but the service coordinator or the HCSSA provider determines the use of this provider type places the individual's health and welfare at risk, the service coordinator should not authorize an attendant with delegated tasks to deliver respite, unless determined appropriate by the member's physician.

If a member or their legally authorized representative (LAR) employs an attendant under the consumer directed services (CDS) option, delegation of certain tasks is not required under the CDS option. Form 1585, Acknowledgment of Responsibility for Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services, outlines what services cannot be delegated, such as specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention. If the member or their LAR is directing the member's services, they must sign Form 1585, acknowledging responsibility for the training and oversight of an attendant.

4712 Out-of-Home Respite

Respite may be provided out of the home if indicated in a physician's order or if the member and/or their legally authorized representative (LAR) prefer. Out-of-home respite providers are:

- special care facilities licensed by the Texas Department of State Health Services (DSHS);

- day care facilities licensed by the Texas Department of Family and Protective Services (DFPS);
- hospitals licensed by DSHS and accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- nursing facilities licensed by the Department of Aging and Disability Services;
- camps licensed by DSHS and accredited by the American Camping Association; and
- foster families approved by a DFPS child placing agency.

Facility-based respite is limited to 29 days per the individual service plan (ISP) period. The 29-day limit applies to the total number of days a member receives respite in a hospital or nursing facility.

4720 Respite Limits

Respite may only be provided during the time the primary caregiver would usually provide care to the member. Respite may not be provided during the time the primary caregiver is at work, attending school or in job training. All respite settings must be located within the state of Texas.

Title 42 of the Code of Federal Regulations §441.301(b)(1)(ii) requires that home and community based services (HCBS), like Medically Dependent Children Program (MDCP) services, not be provided in an institution. However, respite may be provided in a hospital or nursing facility (NF) only if sole reason for the member's admission is respite. For example, if a member is admitted to a hospital for reasons such as illness, surgery, or stabilization/treatments, respite must not be authorized concurrently.

The member may request to exceed the 29-day facility-based respite limit. Within five days of the request to exceed the 29-day limit, the MCO must review the individual’s needs and the primary caregiver’s ability to meet those needs, and determine if the request falls within the respite criteria. The MCO must ensure there is no danger to the member’s health and welfare.

Respite may not be provided in a setting in which identical services are already being provided. This means that a nurse may not provide respite to a member who is receiving out-of-home respite in a camp. Likewise, an attendant may not provide respite to a member receiving out-of-home respite in a NF. Respite may not be delivered by:

- the primary caregiver;
- the member's spouse; or
- the member's parent, representative, guardian or managing conservator, if the individual is under 18.

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Reserved

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Reserved

4750 Flexible Family Support Services

Flexible family support services (FFSS) are individualized and disability-related services that support a member to participate in age-appropriate activities such as:

- child care;
- independent living; and
- post-secondary education.

FFSS include personal care supports for basic activities of daily living (ADL) and instrumental activities of daily living (IADL), skilled task and delegated skilled task supports. FFSS promote community inclusion in typical child and youth activities through the enhancement of natural supports and systems and through recognition that these supports may vary by child, provider, setting and daily routine. Flexible family support services may be delivered by the home and community support service agency (HCSSA) and also may be delivered by attendants or nurses employed through the Consumer Directed Services (CDS) option. FFSS are documented on the individual service plan.

4751 Flexible Family Support Services in Child Care

The member's parent or guardian is responsible for basic child care either in or out of the member's home. Flexible family support services (FFSS) support the member's participation in child care when the service provided by the child care does not support the member's disability-related needs. If the member's child care is not able to meet the member's activities of daily living (ADL), instrumental activities of daily living (IADL), skilled task, non-skilled task or delegated skilled task needs, the service coordinator may authorize FFSS.

To determine the need for FFSS for participation in child care, the service coordinator must discuss the parent's or guardian's plan for obtaining basic child care and whether it will be provided in or out of the member's home or both. The delivery of FFSS does not include basic child care, which is watchful attention or supervision of the member while the primary caregiver is at work, in job training or at school and not available. These remain responsibilities within the service delivered by the child care provider.

The caregiver's cost for child care does not impact the member's need for FFSS. The service coordinator must determine the amount of hours needed to support the member's needs within the Medically Dependent Children Program (MDCP) cost limit. The service coordinator should ask the caregiver about the member's personal and skilled task needs and the time needed to address those needs. The service coordinator should discuss the skill level required to assist the member to address necessary safeguards that ensure the member's health and welfare.

FFSS does not replace personal care services (PCS) provided through Texas Health Steps or Community First Choice (CFC). FFSS are provided when a member regularly participates in child care in the home or out of the home, or participates in a community program or educational service. FFSS are authorized when because of a change in the child's condition or because the child's condition their needs cannot be met. In these instances, additional care is required.

4752 Flexible Family Support Services for Independent Living

A member may indicate a desire for increased independence as he or she matures. If the member needs assistance with activities of daily living (ADL), instrumental activities of daily living (IADL), skilled task, non-skilled task or delegated skilled task, the service coordinator may authorize flexible family support services (FFSS) to help the member with his or her goal for independent living.

Independent living can be an arrangement that maximizes independence and self-determination and offers opportunities to be as self-sufficient as possible. Although independent living is not a Medically Dependent Children Program (MDCP) service, an independent living arrangement can provide life-skills training to assist members in acquiring the skills they will need to live independently as adults.

To determine the need for FFSS for independent living, the service coordinator must discuss the member's and primary caregiver's plan for the member's independent living. When identifying the member's need for this service, the service coordinator should address age appropriateness for the tasks required to meet these needs. The service coordinator must determine the amount of FFSS needed to support the member's needs. The service coordinator should discuss the skill level required to assist the member and the appropriateness of the living arrangement and service delivery regarding the member's age, health and welfare. FFSS may be used only when the primary caregiver is working, attending school or participating in job training.

4753 Flexible Family Support Services in Post-Secondary Education

A member can access flexible family support services (FFSS) to participate in post-secondary education. Post-secondary education institutions do not assist students with activities of daily living (ADL), instrumental activities of daily living (IADL), skilled task, non-skilled task or delegated skilled task needs. If a member has an ADL, IADL, skilled task, non-skilled task or delegated skilled task need prohibiting the member from participating in post-secondary education, the service coordinator may authorize FFSS so the member may participate in post-secondary education.

A member may enroll in a post-secondary school after first attending a secondary school, such as a high school. A post-secondary education may include vocational education and training, as well as participation in college or university. These educational institutions are not subject to the Individuals with Disabilities Education Act. Post-secondary institutions can provide academic adjustments, but do not support the member's personal, skilled and delegated skilled task needs.

To determine the need for FFSS in post-secondary education, the service coordinator must identify the member's need for assistance and the amount of FFSS needed to support the member's needs. The service coordinator should identify the member's personal and skilled task needs and the amount of time needed to address those needs. The service coordinator should discuss the skill level required to assist the member and address necessary safeguards to ensure the member's health and welfare.

4754 Flexible Family Support Services Requiring Delegated Tasks

A delegated task is defined as a task that a practitioner or registered nurse (RN) delegates in accordance with state law. In general, the Texas Board of Nursing (BON) defines nurse delegation as authorizing an unlicensed person to provide nursing services while retaining accountability for how the unlicensed person performs the task. In brief, the Texas Occupations Code indicates a physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate. Only a home and community support services agency (HCSSA) nurse may delegate to an attendant under their supervision, per BON rules. A member with a skilled task need may use an attendant with delegated tasks if a practitioner or RN delegates the skilled task required to meet the member's needs.

If the member does not have a skilled task need for the delivery of flexible family support services (FFSS), he or she does not have a need for an attendant with delegated tasks. If the member or primary caregiver requests the use of an attendant with delegated tasks, but the service coordinator or the HCSSA provider determines the use of this provider type places the individual's health and welfare at risk, the service coordinator should not authorize an attendant with delegated tasks to deliver respite, unless determined appropriate by the member's physician.

If a member or their legally authorized representative (LAR) employs an attendant under the consumer directed services (CDS) option, delegation of certain tasks is not required under the CDS option. Form 1585, Acknowledgment of Responsibility for Exemption from Nursing Licensure for Certain Services Delivered through CDS, outlines what services cannot be delegation, such as specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention. If the member or their LAR is directing the member's services, they must sign Form 1585, acknowledging responsibility for the training and oversight of an attendant.

4760 Flexible Family Support Services Limits

Flexible family support services (FFSS) may be used only when the primary caregiver is working, attending school or participating in job training, and are delivered in a setting where the delivery of similar supports is not already required or included as part of the service. For this reason, the service coordinator may not authorize FFSS during the same time period the individual receives personal care services or Community First Choice (CFC).

42 Code of Federal Regulations §446.301(b)(1)(ii) requires that Medically Dependent Children Program (MDCP) services, including FFSS, may not be provided to a member who is admitted to a hospital or is a resident of a nursing facility (NF) or intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID).

The service coordinator may not authorize FFSS during the member's school hours in primary or secondary educational settings.

4800 Adaptive Aids, Minor Home Modifications, and Transition Assistance Services

4810 Adaptive Aids

Adaptive aids are devices necessary to treat, rehabilitate, prevent or compensate for conditions resulting in disability or loss of function and enable members to:

- perform activities of daily living (ADL); or
- control the environment in which they live.

A member must exhaust any applicable Medicare, Medicaid or other third-party resources for durable medical equipment and adaptive aids before adaptive aids available under the Medically Dependent Children Program (MDCP) are authorized. A member may take an adaptive aid to an out-of-home respite facility for use while residing there.

4811 Service Limits on Adaptive Aids

The service limit on all adaptive aids combined is $4,000 per annual individual service plan (ISP) period. The amount paid for an adaptive aid must be documented on Form H2416; Documentation of MDCP Adaptive Aid, Minor Home Modification, and Transition Assistance, and retained in the member's case file. After any applicable state plan benefits (e.g., durable medical equipment) are exhausted, adaptive aids covered in the Medically Dependent Children Program (MDCP) include:

- van lifts;
- vehicle modifications;
- jump seats;
- tumble form chairs;
- feeder seats;
- medically appropriate strollers;
- barrier-free lifts;
- stair lifts;
- environmental control units;
- alarm systems;
- support rails;
- electrical work related to use of authorized adaptive aids;
- installation of authorized adaptive aids; and
- repairs to adaptive aids.

The managed care organization (MCO) may authorize bids for adaptive aids, such as vehicle modifications, as applicable. The cost of these bids do not count against the member's annual limit for adaptive aids.

If the cost of a requested adaptive aid exceeds the service limit, the MCO may approve the request only if the member agrees to pay any costs that are in excess of the service limit. The MCO must document the member's agreement to pay these costs in the member's case file.

Documentation must include, at a minimum, a description of the adaptive aid, rationale for exceeding the service limit, the cost incurred to the MCO, the cost incurred to the member, the member's signature, the date of the member's agreement, and signature of the provider. Documentation must be on file prior to the MCO authorizing an adaptive aid that exceeds the service limit.

4820 Minor Home Modifications

A minor home modification is a physical modification to a member's residence necessary to prevent institutionalization or support de-institutionalization. Minor home modifications are necessary to ensure the health, welfare and safety of the member or to enable the member to function with greater independence in his or her home. If a home modification is requested and the member or their legally authorized representative (LAR) does not own the home in which the modification will take place, the member, their LAR, or the service coordinator must obtain written agreement from the homeowner before a modification is authorized.

4821 Service Limits on Minor Home Modifications

The minor home modification lifetime limit is $7,500. The service coordinator may authorize up to $300 per the individual service plan (ISP) period for maintenance or repairs of minor home modifications previously approved and reimbursed with waiver funds. The service coordinator does not include $300 maintenance and repair limit as part of the $7,500 lifetime limit. The amount paid for a modification or for the repair of a minor home modification must be documented on Form H2416; Documentation of MDCP Adaptive Aid, Minor Home Modification, and Transition Assistance, and retained in the member's case file. A minor home modification must not create a new structure or add square footage to the home.

The managed care organization (MCO) may authorize bids for minor home modifications, as applicable. The cost of these bids do not count against the member's lifetime limit for minor home modifications.

Minor home modifications are limited to:

- purchase and installation of permanent and portable ramps not covered by other sources;
- widening of doorways;
- modification of bathroom facilities; and
- modifications related to the approved installation or modification of ramps, doorways or bathroom facilities.

Minor home modifications must:

- adhere to Americans with Disabilities Act (ADA) requirements;
- meet Texas Accessibility Standards;
- meet all applicable state and/or local building codes; and
- have a minimum one-year warranty.

Minor home modifications do not include the use of deluxe materials, such as granite, marble or high-end fixtures.

If a request for repair or maintenance to a minor home modification is not covered by the provider's warranty, the service coordinator may authorize up to $300 to the member's or their legally authorized representative's (LAR) to select a provider contracted with the STAR Kids MCO. The $300 limit is available per the member's ISP) year for maintenance and repair and is not included in the $7,500 lifetime minor home modification service limit.

If the cost of a requested minor home modification exceeds the service limit, the MCO may approve the request only if the member agrees to pay any costs that are in excess of the service limit. The MCO must document the member's agreement to pay these costs in the member's case file. Documentation must include, at a minimum, a description of the home modification, rationale for exceeding the service limit, the cost incurred to the MCO, the cost incurred to the member, the member's signature, the date of the member's agreement, and signature of the provider. Documentation must be on file prior to the MCO authorizing a home modification that exceeds the service limit.

4830 Transition Assistance Services

The service coordinator must advise applicants or members who reside in a nursing facility (NF) or members whose Medically Dependent Children Program (MDCP) services are suspended due to NF placement of the availability of transition assistance services (TAS). TAS may be used if the applicant or member needs assistance in setting up a household when relocating into the community from the NF. The applicant or member may access TAS if they:

- plan to rent an apartment;
- plan to rent a house;
- have a home, but the utilities have been off while in the NF;
- have a home, but it may need cleaning, pest eradication or allergen control before it can be occupied again; or
- need belongings moved from the NF to the new residence.

TAS may be available to pay for non-recurring set-up expenses for applicants/ members transitioning from NFs into MDCP and to individuals temporarily suspended from MDCP services due to a temporary NF placement. TAS may be used for those necessary expenses identified as barriers to the applicant's or member's transition into the community to set up a household. TAS may include, but is not limited to, payment or purchases of:

- security deposits required to lease an apartment or house, or deposits required to establish utility services for the home;
- essential furnishings for the apartment or house;
- moving expenses required to move into the house or apartment; and
- site preparation services, such as pest eradication, allergen control or a one-time cleaning before occupancy.

The applicant or member selects a TAS agency from the list of contracted agencies. The STAR Kids Managed care organization (MCO) may require the applicant, member, or their legally authorized representative (LAR) to attest that the items requested for TAS are the basic,

essential needs required to move into the community, and they agree the TAS agency selected is authorized to make the purchases for him or her. The service coordinator must explain to the applicant or member that the service will not be authorized until the applicant or member is determined eligible for MDCP waiver services, and notified in writing that he or she is eligible. The service coordinator must contact the applicant/member or applicant's/member's representative before certification to verify the applicant or member has made arrangements for relocating to the community and has finalized a projected discharge date. The amount of TAS a member received must be documented on Form H2416; Documentation of MDCP Adaptive Aid, Minor Home Modification, and Transition Assistance.

4831 Deposits

The service coordinator may authorize Transition Assistance Services (TAS) to pay deposits, which include security deposits for residential leases and household utilities, including basic telephone service. Security deposits or utility deposits must be in the applicant's or member's name.

Residential Leases
A security deposit is a one-time expense and the amount may be no more than the equivalent of two months' rent. The service coordinator must not authorize TAS to pay rent. TAS may be accessed to pay for pet deposits only if the pet is the applicant's or member's service animal.

Household Utilities
TAS may be used to pay for utility deposits to establish accounts in the applicant's or member's name or to pay for arrears on previous utilities if the account is in the applicant's or member's name and he or she will not be able to get the utilities unless the previous balance is paid. TAS cannot be used for payment toward utilities. TAS may be used to pay for a telephone since it is a basic need, but may not be used to purchase minutes or services for the telephone. The managed care organization (MCO) may have internal policies regarding the type of telephone that may be authorized.

TAS funds can be used to pay for initial setup or reconnection fees for propane or butane service, including the minimal supply of fuel if the utility company requires a minimal supply of fuel to be delivered during the initial or reconnection service call.

Essential Furnishings
TAS household items that, if absent, would pose a barrier to the applicant's or member's transition into the community. Essential furnishings purchased with TAS funds may include furniture, appliances, housewares and cleaning supplies.

Furniture
TAS can be used to purchase furniture such as a bed, recliner or dinette if the applicant's or member's place of residence does not have the needed furniture and the absence of the item prevents the transition into the community.

Appliances
TAS can be used to purchase appliances such as a refrigerator, stove, washer, dryer, microwave oven, electric can opener, coffee pot or toaster if the applicant or member identifies these appliances as needed items.

Housewares
TAS can be used to purchase basic housewares such as pots, pans, dishes, silverware, cooking utensils, linens, towels, a clock and other small items required to set up the household.

Cleaning Supplies
TAS can be used to purchase basic cleaning supplies such as a mop, broom, vacuum, brushes, soaps and cleaning agents required for the household.

Other
TAS can be used to purchase any special request from the applicant or member not included in the general list that meets the criteria as a basic essential furnishing to transition into the community, if approved by the STAR Kids MCO.

4832 Moving Expenses

Transition Assistance Services (TAS) can be used to pay for moving expenses, which may include the cost of moving the applicant's or member's belongings from the nursing facility to the community residence, or delivery charges on approved TAS items.

Moving expenses may include the cost of a designated mover or retail store to deliver or move furniture, major appliances and other items approved as required for relocation to the community. Moving expenses do not include the cost of transporting the applicant or member from the nursing facility to his or her residence in the community.

4833 Site Preparation

Transition Assistance Services (TAS) can be used to pay for preparing the applicant's or member's place of residence for occupancy if the current condition of the residence prevents the applicant's or member's transition from the nursing facility.

Site preparation purchased with TAS funds may include one-time expenses such as pest eradication, allergen control and residential cleaning.

Pest Eradication
TAS can be used if the residence has been unattended and is in need of some type of extermination.

Allergen Control
TAS can be used if the residence has been unattended or the applicant or individual is moving into a place that poses a respiratory health problem.

One-time Cleaning
TAS can be used if the applicant's or member's residence has been unattended or the applicant or member is moving into a private home or apartment where pre-move-in cleaning should not be expected, for example, a family friend has an empty house available but cannot provide the cleaning.

4834 Limits on Transition Assistance Services

The service limit on Transition Assistance Services (TAS) has a $2,500 lifetime limit per applicant or member. The amount paid for TAS must be documented on Form H2416; Documentation of MDCP Adaptive Aid, Minor Home Modification, and Transition Assistance, and retained in the member's case file. The service coordinator must be as specific as possible when describing the items purchased. A nursing facility resident eligible for Medically Dependent Children Program (MDCP) services or members whose MDCP services are suspended due to nursing facility (NF) placement may receive a one-time TAS authorization if the service coordinator determines that no other resources are available to pay for the basic services or items needed by the applicant or member. TAS may not be used for:

- monthly rental or mortgage expenses;
- current or future use of utilities;
- service upgrades;
- food items; or
- any diversional or recreational items or services, including televisions, video players or recorders, movies, games, computers, cable TV, satellite TV, exercise equipment, vehicles or other modes of transportation.

TAS does not include any items or services that may be accessed through other MDCP services, such as adaptive aids or minor home modifications. TAS is only available to applicants or members who are discharged from a nursing facility and require TAS to set up a household.

4835 Transition Assistance Services Agency Responsibilities

The Transition Assistance Services (TAS) agency accepts all members referred by the managed care organization (MCO). Upon receipt of the authorization, the TAS agency must review the authorization carefully and contact the MCO if there are any questions regarding the authorization. This contact must occur by the next business day of receipt of the forms, and before any TAS purchase is made. The MCO contacts the member or their legally authorized representative (LAR), if necessary, to discuss the item in question. The MCO provides a revised TAS authorization within two business days if it clarifies an item is authorized or approves a change to the authorization.

The TAS agency purchases the authorized items/services and arranges and pays for the delivery of the purchased items, if applicable. The TAS agency only purchases services or items within the authorization made by the MCO. The TAS agency contacts the member or member's authorized representative, if necessary, to coordinate service delivery. The TAS agency delivers the authorized services by the completion date recorded on the TAS authorization form. The agency provides a copy of the purchase receipts and any original product warranty information to the member. The TAS agency maintains the original purchase receipts, including sales tax, delivery or installation charges.

The TAS agency orally notifies the MCO of a delivery delay before the completion due date and documents the delay. The agency also contacts the member or the member's representative by the completion date to confirm that all authorized TAS services were delivered.

4836 Three-Day Monitor Requirement

The managed care organization (MCO) monitors the member within three business days following the discharge date to assure the delivery of all services and items authorized through the Transition Assistance Services (TAS) agency. If the member reports that any items have not been delivered or services not performed, the MCO contacts the TAS agency by telephone and follows up in writing. Written documentation must be maintained in the member's case record.

4837 Failure to Leave the Facility

While the managed care organization (MCO) makes every effort to confirm the member has definite plans to leave the facility, there may be situations in which the member changes their mind or has a change in their health making it impossible for him or her to relocate to the community as planned. In this situation, the MCO notifies the Transition Assistance Services (TAS) agency that the member is no longer moving and no further items are to be purchased.

The TAS agency must attempt to return any item(s) purchased on behalf of the individual and collect a refund for the amount of the purchase. The TAS agency also must attempt to recoup security, utility and other deposits paid on behalf of the individual. Failure to leave a facility does not count against a member's lifetime TAS limit.

- If the TAS agency is unsuccessful in returning the item(s) for the amount of monies paid, or the deposits paid on behalf of the individual cannot be recouped, the TAS agency is entitled to the cost of the item(s) and/or reimbursement for deposits paid, not to exceed the authorized amount. The TAS agency sends the MCO written notice stating the item(s) could not be returned or the deposits could not be recouped. The MCO contacts a local charity to donate the items and makes arrangements for pick up. The charity must serve individuals whose needs are similar to those of the individual for whom the items were purchased or must be dedicated to assisting individuals establish a home.
- If the TAS agency is able to return the item(s) or receives the deposits back, the TAS agency is not entitled to reimbursement. If the TAS agency recoups part of the monies paid, the TAS agency is entitled to the costs of the item(s) or deposits less any monies recouped. Any claims that had been filed and paid for the item(s) or deposits would need to be adjusted by the TAS agency to pay the monies back to the MCO.
- If a service has already been provided (for example, pest eradication), the TAS agency is entitled to the costs of the service, not to exceed the authorized amount.

If the member is only in the community for a few days and returns to the nursing facility, the member keeps the item(s) purchased through TAS.

4900 Supported Employment and Employment Assistance

Senate Bill 45, 83rd Legislature, Regular Session, 2013, required all Medicaid waivers offer employment assistance (EA) and supported employment (SE). Employment services are intended to assist members to find employment and maintain employment. Employment services available for members in the Medically Dependent Children Program (MDCP) are EA and SE.

4910 Employment Assistance

Employment assistance (EA) is provided to a member receiving Medically Dependent Children Program (MDCP) waiver services to help the individual locate paid employment in the community and includes:

- identifying a member's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with a member's identified preferences, skills and requirements; and
- contacting a prospective employer on behalf of a member and negotiating the member's employment.

For any MDCP member, the service coordinator must ensure and document that employment services are not available to the member from the member's school district or other available community resource before authorizing waiver EA services.

The service coordinator refers the member to the Texas Workforce Commission (TWC) within 30 days of meeting with a member and identifying an interest in obtaining employment. The service coordinator should contact the local TWC office to identify the referral process used by that office. Local TWC offices may be located at http://www.twc.state.tx.us/directory-workforce-solutions-offices-services-0#workforceServices

A member who has been referred for TWC or contacted TWC themselves is not eligible to receive EA through MDCP until TWC has developed the Individualized Plan of Employment (IPE) and the member has signed it, or until the member is denied services through TWC. If a member refuses to contact TWC, he or she may not receive waiver-funded EA. If a member is denied assistance through TWC, EA through MDCP may be authorized.

If the member has exhausted TWC services or been determined ineligible for TWC services, the service coordinator authorizes a minimum of 10 hours for employment on the member's individual service plan (ISP). Employment assistance can be authorized up to 180 days. The member or provider may request more hours for EA, if needed, and funds are available in the member's MDCP budget.

4911 Coordination with Texas Workforce Commission for Employment Assistance

Upon request and with proper authorization for disclosure, the service coordinator will assist the member to provide the Texas Workforce Commission (TWC) Vocational Rehabilitation Counselor (VRC) with the following items from a member:

- Photo identification;
- An original Social Security card;
- Member's home address and mailing address;
- Names and addresses of any doctors the member has seen recently;
- Names and addresses of any schools the member has attended;
- Information about the member's medical insurance;
- A list of places the member has worked, including type of job, dates, the reason for leaving and salary;

- Proof of income for the member and his or her spouse, or parents (if the parents claim the member as a dependent on their income tax);
- Proof of expenses related to monthly mortgage/rental payments, debts imposed by court order, personal medical costs and other disability-related expenses;
- Names, addresses and phone numbers of two people who will always know how to contact the member;
- Any reports of recent medical exams, school records or other information that may help the VRC understand the member's disability;
- Member's most recent service plan;
- Any current vocational assessments or person-directed plans that focus on employment opportunities;
- Any other available records pertaining to the member's disabilities, including but not limited to medical, psychological and psychiatric reports;
- A copy of the member's court-ordered guardianship documents, if any guardian has been appointed; and
- Contact information for the member's service coordinator.

If the VRC determines that TWC is not the appropriate resource to meet the member's needs and does not take an application for services, documentation of this decision in the member's record serves as sufficient evidence that TWC is not available and the member is eligible to receive waiver-funded employment assistance.

TWC will:

- Notify a member in writing if the member is determined to be eligible, ineligible or if TWC is unavailable;
- Notify a member in writing when TWC is completed;
- Develop with the eligible member an individual plan for employment (IPE) within 90 days of determination of eligibility for services;
- After the IPE is completed, begin coordinating the provision of services as identified on the IPE; and
- Upon request and with proper authorization for disclosure, provide copies of any of the member's records to the service coordinator, including the following documents:

    - A completed copy of the member's application statement;
    - A member's completed IPE;
    - Written documentation specifying a member's eligibility status; and
    - The notification letter indicating TWC is completed.

If TWC has not notified the member of an eligibility decision within 60 days of the initial TWC appointment, the member's service coordinator will attempt to contact the assigned TWC VRC to determine the status of the application and document the contact in the narrative notes.

The member's service coordinator will ensure that communication is maintained TWC the assigned TWC VRC regarding waiver-funded services provided between the Vocational Rehabilitation (VR) referral and the "start date" of TWC, as defined in the individual's TWC VR IPE.

At the request of a member determined eligible for TWC, the service coordinator, if possible, will assist the member and:

- participate in TWC planning meetings related to the member's employment, or ensure other individuals important to the member attend, as appropriate;
- take an active role in providing input to the TWC (IPE), or ensure other individuals important to the member provide input, as appropriate;
- review the long-term services and supports listed on the TWC IPE and if any of those services and supports are available through the waiver, incorporate them in a revision to the member's service plan prior to the end of TWC services.

The member's provider must begin providing or subcontracting for those services and supports approved in the member's service plan without a gap between the provision of TWC and waiver services.

4912 Employment Assistance Providers

Employment assistance providers are either employed by a licensed home and community support services agency (HCSSA), also called a home health agency, or are employed by a member or their legally authorized representative (LAR) under the consumer directed services (CDS) option. As a minimum, the employment assistance provider must be at least 18 years of age, maintain current driver's license and insurance if transporting individual, and satisfy one of these options:
Option 1:

- a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six months of paid or unpaid experience providing services to people with disabilities.

Option 2:

- an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one year of paid or unpaid experience providing services to people with disabilities.

Option 3:

- a high school diploma or Certificate of High School Equivalency (GED credentials), and
- two years of paid or unpaid experience providing services to people with disabilities.

Under the CDS option, the provider cannot be the member's legal guardian or the spouse of the legal guardian.

4920 Supported Employment

Supported employment (SE) services provide assistance to help a member receiving Medically Dependent Children Program (MDCP) services sustain competitive employment or self-employment. Supported employment services include:

- assistance provided to a member to sustain competitive employment, and who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which individuals without disabilities are employed;
- employment adaptations, supervision and training related to a member's assessed need; and
- ensuring members earn at least minimum wage, if not self-employed.

Competitive employment is work:

- in the competitive labor market in which anyone may compete for employment that is performed on a full-time or part-time basis in an integrated setting; and
- for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

An integrated setting is a setting typically found in the community in which members interact with people without disabilities, other than service providers, to the same extent that people without disabilities in comparable positions interact with other people without disabilities. An integrated setting **does not** include a setting in which:

- groups of people with disabilities work in an area that is not part of the general workplace where people without disabilities work; or
- a mobile crew of people with disabilities work in the community.

An MDCP member may seek SE to provide assistance to the member in maintaining self-employment. Self-employment is work in which the member:

- solely owns, manages and operates a business;
- is not an employee of another person, entity or business; and
- actively markets a service or product to potential customers.

Supported employment may only be authorized through the MDCP waiver if documentation is maintained in the member's record that the service is not available to the member under a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq.) or the Texas Workforce Commission (TWC).

4921 Coordination with Texas Workforce Commission for Supported Employment

The service coordinator coordinates with the Texas Workforce Commission (TWC) and the local school districts, seeking third party resources before using Medically Dependent Children Program (MDCP) employment services, including school districts.

Activities include:

- devoting time during a member's initial service planning meeting to discuss employment with the member and family and the process to obtain employment services and supports;

- making a referral to TWC, assisting with completing the application form, and documenting the referral and outcome of the referral in the member's case record;
- continuing to explore the possibility of employment at subsequent service planning meetings for a member who is not employed in the community;
- affirming or explaining how a member can work and still maintain current medical benefits (e.g., through the Medicaid Buy-In program), and in most cases will have an increase in income;
- explaining rights to appeal if services are denied, reduced or terminated; and
- monitoring whether the member and family are satisfied with the employment supports.

4922 Supported Employment Providers

Supported employment (SE) providers are either employed by a licensed home and community support services agency (HCSSA), also called a home health agency, or are employed by a member or their legally authorized representative (LAR) under the consumer directed services (CDS) option. As a minimum, the SE provider must be at least 18 years of age, maintain current driver's license and insurance if transporting individual, and satisfy one of these options:

Option 1:

- a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six months of paid or unpaid experience providing services to people with disabilities.

Option 2:

- an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one year of paid or unpaid experience providing services to people with disabilities.

Option 3:

- a high school diploma or Certificate of High School Equivalency (GED credentials), and
- two years of paid or unpaid experience providing services to people with disabilities.

Under CDS, the provider cannot be the member's legal guardian or the spouse of the legal guardian.

Section 5000 Service Delivery Options

5010 Selection of a Service Delivery Option

Service coordinators must present all service delivery options to the applicant/member and/or the legally authorized representative at the initial assessment and each annual reassessment. In addition to the documents described in Section 5221 the managed care organization (MCO) may use Form 1581, Consumer Directed Services Overview, and Form 1582, Consumer Directed Services Responsibility, or a document created by the MCO and approved by Health and Human Services Commission, to assist the member or applicant in making the service delivery decision.

MCOs must obtain a signature on Form 1584, Consumer Participation Choice, indicating the member's choice of option. If, at any time during the year, a current member calls requesting information on service delivery options, the MCO must present the information to the member.

5020 Member Decision

The managed care organization (MCO) must keep Form 1584, Consumer Participation Choice, in the member's case record. The MCO must ensure the member understands he/she may request a service delivery option change at any time by contacting the MCO.

5100 Agency Option (AO)

5110 Description

Under the agency option (AO), the managed care organization-contracted provider is responsible for managing the day-to-day activities of the direct service provider and all business details. Some individuals select the AO because of the simplicity and convenience of receiving services. For example, under AO the agency, not the member, is responsible for:

- locating qualified attendant(s) to provide services;
- any negligent acts or omissions by the attendant(s), and liability for those acts;
- handling all conflicts with the attendant(s);
- any business details related to service delivery; and
- training the attendant(s).

5200 Consumer Directed Services

5210 Overview

The consumer directed services (CDS) option was codified in Section 531.051 of the Government Code and expanded by the 79th Texas Legislature to provide more options for members to direct their long term services and supports. The rules for the CDS option are found in Texas Administrative Code, Title 40, Chapter 41.

CDS is a service delivery option in which a member or legally authorized representative (LAR) becomes the CDS employer of record for certain services. The CDS employer recruits, selects, trains, and supervises service providers and directs the delivery of services available through the CDS option, described in Section 5212. CDS employers are required to use a financial management services agency (FMSA), contracted with the managed care organization (MCO) that they choose to provide financial management services (FMS). FMSA's conduct payroll and pay employer federal and state taxes on behalf of CDS employers, and provide orientation and on-going support for members who choose the CDS option. FMSA roles and responsibilities are explained in more detail in Section 5800.

A member or LAR may elect the CDS option if:

- the member's services offer the CDS option;
- the CDS employer agrees to perform the employer responsibilities required for participation in the CDS option;
- the member or LAR selects a FMSA to provide FMS; and
- the member or LAR has developed and received approval from the service planning team for each required service back-up plan.

5211 Consumer Directed Services Definitions

The following words and terms, when used in reference to the consumer directed services (CDS) option, have the following meanings.

Budget — A written projection of expenditures for each service delivered through the CDS option.

Designated representative (DR) — A willing adult appointed by the CDS employer to assist with or perform the employer's required responsibilities to the extent approved by the employer. The DR is not the CDS employer.

Employee — A person employed by the member or legally authorized representative (LAR) through a service agreement to deliver program services and is paid an hourly wage for those services.

Employer— The member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining service providers to deliver program services.
Employer support services — Services and items needed and allocated in the member's budget for the member or LAR to perform employer and employment responsibilities, such as office equipment and supplies, expenses related to recruiting employees, and other items approved in Texas Administrative Code, Title 40, Part 1, Chapter 41, §41.507.

Financial Management Services (FMS) — Financial management services delivered by the financial management service agency (FMSA) to the member or LAR, as described is Section 5232, such as orientation, training, support, assistance with and approval of budgets, and processing payroll and payables on behalf of the member or LAR.

Legally authorized representative (LAR) — A person authorized by law to act on behalf of a member, including a parent of a minor, guardian of a minor, managing conservator of a minor or the guardian of an adult.

Service Back-Up Plan — A documented plan to ensure that critical program services delivered through the CDS option are provided to a member when normal service delivery is interrupted or there is an emergency.

5212 STAR Kids Services Available Under the Consumer Directed Services Option

STAR Kids services for which the consumer directed services (CDS) Option are available are:

- Community First Choice (CFC) Personal Assistance Services (PAS),
- CFC Habilitation, and
- Personal Care Services (PCS).

The Medically Dependent Children Program (MDCP) waiver services available in the CDS option are:

- In-home Respite;
- Flexible Family Support Services;
- Supported Employment; and
- Employment Assistance.

STAR Kids members may choose to self-direct any or all services available through the CDS option. The CDS option is available to members living in their own homes or the homes of family members.

All applicants and ongoing members will be assessed for financial and functional eligibility using the STAR Kids Screening and Assessment Instrument (SK-SAI). Choosing the CDS option in no way impacts a member's eligibility for services. Members have the option of having services delivered through a contracted Home and Community Support Services Agency (HCSSA) provider using the agency or service responsibility options, or through the CDS option, in which they hire and manage their own employees to provide the services.

Financial management services (FMS), a required service under the CDS option, provides assistance to members to manage funds associated with services elected for self-direction, and is provided by the financial management service agency (FMSA). This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. If requested, an FMSA can provide support consultation, which is extra help training, working with, and if necessary, dismissing an employee, provided by a support advisor. FMSAs also conduct payroll and pay employer taxes on behalf of the employer. A monthly administrative fee is authorized on the individual service plan and paid to the FMSA for FMS.

5220 Advantages and Risks of the Consumer Directed Services Option

The member should consider the advantages and risks associated with the consumer directed services (CDS) option before choosing to enroll. To assist the member in making an informed choice, information is presented by the service coordinator. Refer to Section 5221, Advantages of Consumer Directed Services Service Delivery Option.

5221 Advantages of Consumer Directed Services Service Delivery Option

Below are some of the advantages associated with the consumer directed services (CDS) option. The member or legally authorized representative:

- has more control over who provides services and the days and times the services are delivered;
- can offer benefits, such as bonuses, vacation pay, sick pay and insurance to the attendants or nurses, in consultation with the financial management service agency (FMSA);
- can control the final rate of pay for direct service providers within the bounds of the unit rate established by the managed care organization (MCO) as a maximum and at least $8.00 per hour, or the wage floor established by the Texas Legislature;
- may be able to recruit eligible service providers, including family members, friends and other persons they know;
- may be able to appoint someone to assist with employer responsibilities or to perform employer responsibilities;
- may use some of the budgeted funds to hire a support advisor, if they need assistance above and beyond what the FMSA provides; and
- train service providers and supervise the services delivered by their service providers.

5222 Potential Risks Associated with the Consumer Directed Services Option

Below are some of the potential risks associated with the consumer directed services (CDS) option. The member or legally authorized representative (LAR) is:

- responsible for locating attendants or back-up attendants. The member or LAR may contract with a Home and Community Support Services Agency (HCSSA) provider to provide back-up services;
- the employer in the CDS option and assumes all liability. The member or LAR retains control over hiring, managing and firing employees. The persons providing services are not the employees of the financial management service agency (FMSA), the managed care organization, any state or federal agency or other contracted provider agency. The member or LAR is solely responsible and liable for any negligent acts or omissions as the employer or by the employee, other employees, service providers and the designated representative;
- responsible for handling all conflicts with the attendant. The FMSA and service coordinator are not involved;
- not able to change or increase the managed care organization (MCO)-authorized service hours by paying the attendants less;
- required to keep certain paperwork to be specified by the FMSA for a required time period. The member or LAR must safely store the documentation for five years or longer;
- required to understand that while the FMSA is responsible for payroll taxes owed to the Internal Revenue Service (IRS) and Texas Workforce Commission (TWC), the employer is jointly liable if the FMSA fails to pay; and
- responsible for meeting all state and federal requirements as an employer and can be held liable for failure to meet those requirements.

5230 Member and Financial Management Service Agency Responsibilities

5231 Member Responsibilities

The member or legally authorized representative (LAR) assumes responsibility as the employer of record. The member and/or their legally authorized representative are responsible for:

- recruiting, hiring, training, managing and firing direct service providers;
- setting wages and benefits for direct service providers within funds allocated for services elected for delivery through the consumer directed services (CDS) option;
- following state and federal laws including the payment of overtime;
- evaluating each service provider's job performance;
- approving, signing and submitting time sheets, invoices and receipts to the financial management service agency (FMSA) for payment to direct service providers;
- providing the FMSA with necessary information to register as the member’s agent with the Internal Revenue Service and the Texas Workforce Commission;
- having the FMSA verify eligibility of each applicant before hiring or retaining for employment or service delivery;
- resolving employee and service provider concerns and complaints;
- maintaining a personnel file on each service provider;
- developing and implementing backup service plans for services determined by the individual's planning team to be critical to the individual's health and welfare; and
- ensuring protection of the individual receiving services and preserving evidence in the event of a Department of Family and Protective Services (DFPS) Adult Protective Services (APS) investigation of an allegation of abuse, neglect, or exploitation (ANE) against a CDS employee, designated representative (DR), FMSA representative, or case manager or service.

5232 Financial Management Service Agency Responsibilities

Under the consumer directed services (CDS) option, a financial management service agency must:

- orient and train the employer/designated representative (DR) about employer responsibilities for the CDS option to include legal requirements of various governmental agencies;
- assist and approve budgets for each service to be delivered through CDS;
- provide assistance in completing forms required to obtain an employer identification number (EIN) from federal and state agencies;
- conduct criminal history checks and registry checks of applicants;
- verify each applicant's eligibility with program requirements, including Medicaid fraud exclusions, before an applicant is employed or retained by the employer;
- register as your employer-agent with the Internal Revenue Service (IRS) and assume full liability for filing reports;
- pay employer taxes on the CDS employer's behalf, to the IRS and Texas Workforce Commission (TWC);

- receive and process employee time sheets, compute and pay all federal and state employment-related taxes and withholdings, and distribute payroll at least twice a month;
- receive and process invoices and receipts for payment;
- maintain records of all expenses and reimbursement and monitor budget;
- submit claims to the member's managed care organization (MCO);
- provide written summaries and budget balances of payroll and other expenses at least quarterly;
- prepare and file employer-related tax and withholding forms and reports (this does not include filing personal income tax returns for you or your employees); and
- provide ongoing training and assistance as needed or requested.

The financial management service agency (FMSA) must obtain employer-agent status as define by IRS Rev. Proc, 2013-39 and perform all responsibilities as required by the IRS and other appropriate government agencies. The FMSA must enter into service agreements with each of the member's direct service providers before issuing payment.

5240 Member Choice in the Consumer Directed Services Option

Information about the consumer directed services (CDS) option is presented to the STAR Kids member by the service coordinator. Written and verbal information is shared about the benefits and requirements of the CDS option. The member chooses which services will be delivered through the CDS option and which will be through the agency or service responsibility option.

5241 Presentation of the Consumer Directed Services Option

The service coordinator is responsible for offering the consumer directed services (CDS) option to all new STAR Kids members and Medically Dependent Children Program (MDCP) applicants, annually to current members who are not enrolled in the CDS option, and whenever information is requested. The service coordinator:

- shares an overview of the benefits and responsibilities of the CDS option by reviewing Form 1581, Consumer Directed Services (CDS) Option Overview; and Form 1582, Consumer Directed Services Responsibilities;
- provides a copy of Form 1581 to the applicant/member; and
- informs the applicant/member of the right to choose service delivery through the agency option or the CDS option.

The service coordinator obtains the member or applicant's signature on Form 1581 at the initial contact. The service coordinator signs and dates the form verifying the information was presented to the member or applicant. A copy of Form 1581 is placed in the case record to document that CDS information was shared.

At annual reassessment, the service coordinator provides the member with a copy of Form 1581 and clearly documents in the case record that Form 1581 was shared with the member.

When members request information about the CDS option at other times, the service coordinator must provide CDS information to the member within five business days after receipt of the request. The service coordinator may provide the information by making a home visit or contacting the individual by telephone. If a home visit is not made, the service coordinator

obtains the member's signature by mailing Form 1581 to the member with a postage-paid, return envelope. The service coordinator signs and dates Form 1581 indicating the information was presented. A copy of Form 1581 is placed in the member's case record to document Form 1581 was shared.

If the member is still interested in participating in the CDS option once the information on Form 1581 is shared, the service coordinator reviews Form 1582. The service coordinator:

- reviews with the member or legally authorized representative (LAR) the responsibilities, risks and advantages of the CDS option;
- assists the member as needed in completing the individual self-assessment on Page 4 of Form 1582;
- obtains the designated representative's (DR's) dated signature if the appointment of a DR is required based on the assessment;
- obtains the member's or LAR's dated signature on Form 1582; and
- signs and dates Form 1582.

If an individual or LAR (the employer) is not able to complete the Consumer Self-Assessment, a person appointed by the employer to be the employer's DR must be able to complete the Consumer Self-Assessment for the individual receiving services to participate in the CDS option.

If an employer would like to use a DR, the financial management services agency (FMSA) assists the employer in appointing a DR.

5300 Initiating the Consumer Directed Services Option

Once a member and/or their legally authorized representative (LAR) has chosen the consumer directed services (CDS) option, the service coordinator presents a list of contracted financial management services agencies (FMSAs). The individual must select an FMSA to perform CDS financial management services.

If the member or LAR chooses the CDS option, the service coordinator proceeds to Form 1583, Employee Qualification Requirements, and Form 1584, Consumer Participation Choice, and Form 1586, Acknowledgement of Information Regarding Support Consultation Services in the Consumer Directed Services (CDS) Option. The service coordinator:

- provides Form 1583 information on the additional responsibilities of being an employer in the CDS option and who may or may not be hired in the CDS option;
- shares Form 1584 indicating the applicant's/member's or LAR's selection of the CDS option;
- provides Form 1586 information about support consultation;
- obtains the applicant's/member's or LAR's dated signature on Form 1583, Form 1584, Form 1586 if applicable; and
- signs and dates the forms.

The service coordinator develops the member's service plan according to policy and CDS option rules.

5310 Declining the Consumer Directed Services Option

If the member or legally authorized representative (LAR) declines or is not ready to select the consumer directed services (CDS) option at any point after Form 1581, Consumer Directed Services Overview, is shared, the service coordinator:

- obtains the applicant's/member's or LAR's signature on Form 1584, Consumer Participation Choice, indicating his/her selection of the agency option; and
- signs and dates Form 1584.

The service coordinator must ensure the member understands the CDS option is always available and that the individual may call the service coordinator to request a change to the CDS option at any time.

Form 1584 is signed by the member when a different service delivery option is chosen. The member must wait 90 days before switching to a different service delivery option.

5320 Determining the Individual Service Plan

All existing Medicaid eligibility requirements apply in the consumer directed services (CDS) option. CDS is not a different program; it is a service delivery option. The service coordinator completes all forms currently required for STAR Kids services.

The member using the CDS option must have a back-up system to assure the provision of certain or critical authorized CDS services without a service break, even if there are unexpected changes in personnel. The member or legally authorized representative must develop and receive approval from the service coordinator for each required service back-up plan in order to participate in the CDS option. Refer to Section 5325, Service Back-Up Plans.

If the member hires a nurse to provide services, nurses must operate within their license requirements outlined in the Texas Board of Nursing regulations (Texas Administrative Code, Title 22, Part 11), including registered nurse (RN) or physician oversight, plan of care development for nurses depending on the level of nurse hired, and RN or physician delegation as indicated.

The service coordinator follows program policy when completing denials or terminations, reductions in services and suspensions. The service coordinator must ensure the member fully understands the reasons for actions taken relating to the individual service plan and STAR Kids services, as well as actions that could affect the member's participation in the CDS option.

5321 Initiation of and Transition to the Consumer Directed Services Option

Within five business days of receipt of the completed Form 1584, Consumer Participation Choice, existing STAR Kids members who choose the consumer directed services (CDS) option are referred to the financial management services agency (FMSA) they selected to begin the CDS initiation process.

The service coordinator provides the FMSA the following documentation:

- Form 1584, Consumer Participation Choice;

- Form 1582, Consumer Directed Services Responsibilities; and
- the individual service plan and any related addenda.

The service coordinator must provide the FMSA with the authorized schedule of service delivery per day, week, month or other time frame specific to the service if not listed on the above forms.

Members who participate in the CDS option and choose to transfer back to the Agency Option will not have the choice of returning to the CDS option for at least 90 days. Service coordinators must carefully coordinate transition activities when transitioning members to and from the CDS option.

5322 Initiation and Orientation of the Member as Employer

Upon receipt of the consumer directed services (CDS) referral from the service coordinator, the financial management service agency (FMSA) completes the initial employer orientation with the member, legally authorized representative (LAR) and designated representative (DR) (if one is appointed) in the member's residence or setting of their choosing. The FMSA provides an overview of the CDS option, including the rules and requirements of applicable government agencies, and the roles of the employer and the FMSA.

The member, LAR and DR (if one is appointed) signs and submits all required forms for participation in the CDS option and returns the forms to the FMSA within five calendar days after the date of initial orientation.

5323 Employer and Employee Acknowledgment of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services

If the consumer directed services (CDS) employer is going to assume responsibility for training and supervising an unlicensed service provider to perform certain health related tasks, the financial management service agency (FMSA) assists the member, legally authorized representative (LAR) or designated representative (DR) in completing the employer and employee acknowledgment. Tasks prohibited from delegation are described in the Texas Administrative Code, §225.13, Tasks Prohibited From Delegation. The employee acknowledges that, as the person who delivers the service, he/she has not been:

- denied a license under Chapter 301 or 302, Occupations Code; or
- issued a license under Chapter 301, Occupation Code, that is revoked or suspended.

The FMSA verifies potential service providers selected by the member, LAR or DR meet provider qualifications and other requirements of the STAR Kids program before the member, LAR or DR hires the service provider.

5324 Authorizing Consumer Directed Services

For members new to consumer directed services (CDS), following orientation the member or legally authorized representative (LAR) and financial management services agency (FMSA) notify the service coordinator that CDS services are ready to begin, the service coordinator negotiates a start date for services. The service coordinator revises Form 2604, STAR Kids Individual Service Plan - Service Tracking Tool, and changes the appropriate CDS services

authorizations to the FMSA. For ongoing members, the individual service plan year remains the same. The same procedures are followed for any other transfer of agencies.

It is the responsibility of the member, LAR and the FMSA to ensure that the expenditures for the year remain within the authorized amount. The managed care organization (MCO) is responsible for timely payment of FMSA claims, submitted on behalf of the CDS employer, as well as for payment of the monthly service fee, which pays the FMSA for their services.

5325 Ongoing Requirements

The financial management services agencies (FMSA) must send a quarterly expenditure report to the employer and service coordinator (SC) and document and notify the managed care organization (MCO) of issues or concerns, including:

- allegations of abuse, neglect, exploitation or fraud;
- concerns about the member's health, safety or welfare;
- non-delivery or extended breaks in services;
- noncompliance with employer responsibilities;
- noncompliance with service back-up plans; or
- over- or under-utilization of services or funds allocated in the member's service plan for delivery of services to the member through the consumer directed services (CDS) option and in accordance with the requirements of the STAR Kids program.

The CDS employer is required to participate in the service planning meetings and provide requested documentation related to services and service delivery. The member or legally authorized representative (LAR) must provide documentation to support any requests for a revision to the individual service plan.

The FMSA may also participate in the member's service planning if requested by the member, LAR or designated representative (DR) and if agreed to by the FMSA. The MCO and service planning team members, as appropriate, participate in approving back-up plans, developing corrective action plans, if necessary, and recommending suspension or termination of the CDS option. Refer to Section 5235, Service Back-Up Plans and Section 5326, Corrective Action Plans.

5326 Service Back-Up Plans

The managed care organization (MCO) must discuss with the member, legally authorized representative (LAR) or designated representative (DR) the services delivered through consumer directed services (CDS) that are critical to the member's health and welfare. The MCO must inform the member, LAR or DR to develop a service back-up plan to ensure the health and safety of the member when regular service providers are not available to deliver services or in an emergency. The member, LAR or DR must develop a back-up plan, and document the plan on Form 1740, Service Backup Plan, to assure the provision of all authorized personal assistance services without a service break.

The member, LAR or DR, with the assistance of the MCO (if needed), completes Form 1740, Service Backup Plan. The service back-up plan must list the steps the member, LAR or DR implements in the absence of the service provider. The service back-up plan may include the use of paid service providers, unpaid service providers such as family members, friends or non-

program services, or respite (if included in the authorized service plan). The member, LAR or DR is responsible for implementation of the service back-up plan in the absence of the employee.

Service back-up plans are submitted by the member, LAR or DR to the MCO. The MCO and service planning team, as appropriate, approve the plans as being viable in the event a service provider is absent. The MCO or service planning team must approve each service back-up plan and any revision before implementation by the member, LAR or DR. The MCO approves the service back-up plan by signing, dating and returning a copy of the plan to the member, LAR or DR.

The member, LAR or DR is required to:

- budget sufficient funds in the CDS option budget to implement a service back-up plan;
- review and revise each service back-up plan annually;
- revise a service back-up plan if:
    - the member experiences a problem in the implementation, or
    - there are changes in availability of resources;
- redistribute funds that are not used in carrying out a service back-up plan; and
- provide a copy of the initial and revised service back-up plans and budgets to the financial management services agency (FMSA) within five business days after a plan's approval by the service planning team.

The FMSA must assist a member, LAR or DR as requested to revise budgets to:

- meet service back-up plan strategies approved by the member's service planning team;
- reimburse documented, budgeted, allowable expenses incurred related to implementing service back-up plan strategies; and
- retain a copy of service back-up plans received from the member, LAR or DR.

5327 Corrective Action Plans

The consumer directed services (CDS) employer, meaning the member or legally authorized representative (LAR) or designated representative (DR) must provide written corrective action plans (CAP) to the person requiring the plan within 10 calendar days after receiving a CAP request. CAPs may be requested in writing by the financial management services agencies (FMSA) or managed care organization (MCO).

The written CAP must include the:

- reason the CAP is required;
- action to be taken;
- person responsible for each action; and
- date the action must be completed.

The member, LAR or DR may request assistance in the development or implementation of a CAP from the:

- FMSA or others, if the plan is related to employer responsibilities; and

- MCO, if the CAP is related to the Medically Dependent Children Program (MDCP) waiver STAR Kids rules or requirements.

Form 1741, Corrective Action Plan, is used to document the CAP.

5328 Budgets

The member, legally authorized representative (LAR) or designated representative (DR) with the financial management service agency (FMSA) develops a budget for each STAR Kids service to be delivered through the consumer directed services (CDS) option based on the projected expenditures allocated in the individual service plan period. The member must budget the monthly amount established by the Health and Human Services Commission (HHSC) for payment of financial management services delivered by the FMSA through the CDS option.

The member, LAR or DR develops an initial and annual budget and receives written approval from the FMSA before implementation of the budget and initiation of service delivery through the CDS option.

The FMSA must provide assistance as requested or needed by the member, LAR or DR to develop a budget. The FMSA reviews the member's budgeted payroll spending decisions, verifies the applicable budget workbooks are within the approved budget, and notifies the member in writing of budget approval or disapproval. The FMSA must work with the member, LAR or DR to resolve issues that prevent the approval of budget plans.

The member, LAR or DR must submit budget revisions to the FMSA for approval. Revised budgets cannot be implemented until written approval is received from the FMSA. The FMSA must provide assistance to the member, LAR or DR with budget revisions as requested or needed by the member, validate the budget, and provide written approval to the member, LAR or DR.

The managed care organization evaluates service plan changes requested by the member and participates in the service planning team meetings to resolve issues when the member does not follow the budget or comply with CDS option budget requirements.

5400 Service Responsibility Option Description

Service responsibility option (SRO) is a service delivery option that empowers the member to manage most day-to-day activities. This includes supervision of the individual providing direct services. The member decides how services are provided. The SRO leaves the business details to the member's managed care organization. The rules for the SRO are found in Texas Administrative Code, Title 40, Chapter 43.

5410 Service Responsibility Option Roles and Responsibilities

Form 1582-SRO, Service Responsibility Option Roles and Responsibilities, specifies the roles and responsibilities assigned to the member, provider and managed care organization (MCO). The member, provider, and MCO receive and sign Form 1582 indicating their agreement to accept the service responsibility option (SRO) responsibilities.

5411 Managed Care Organization Responsibilities

The intake, referral and assessment procedures for members requesting service delivery through the service responsibility option (SRO) are handled in the usual way. The managed care organizations (MCOs) are responsible for:

- ensuring the member has an opportunity to make an informed choice by providing an objective and balanced review of the options; and
- monitoring the quality of services and service delivery.

Once the assessment is complete, the MCO is required to:

- inform the member about all options for managing services; and
- review Form 1582-SRO, Service Responsibility Option Roles and Responsibilities, with the member to determine if the SRO is an appropriate choice.

In addition, the MCO's responsibilities include:

- presenting all service delivery options;
- documenting the member's choice on Form 1584, Consumer Participation Choice;
- explaining SRO rights, responsibilities and resources to the member;
- presenting the MCO provider list and the support consultation provider to the member;
- making a referral to the provider(s) selected by the member;
- processing the member's request to change service delivery options;
- redeveloping the service plan when a member's needs change;
- serving as a resource if the member has health or safety concerns, issues involving the attendant or other service-related concerns;
- convening a service planning team meeting in instances where the member:
    - has health and safety concerns;
    - is having difficulty selecting or keeping an attendant; or
    - has other issues relating to services that cannot otherwise be resolved; and
- monitoring services in accordance with Section 5422, Monitoring.

5412 Agency Responsibilities

The agency contracted with the managed care organization is the attendant's employer and handles the business details (for example, paying taxes and doing the payroll). The agency also orients attendants to policies and standards before sending the attendants to members' homes.

The agency:

- discusses and negotiates potential back-up plans for those times when the attendant is absent from work;
- sends a maximum of three attendants, including any individuals recommended by the member, for the member to review;
- explains to the selected attendants that the agency is the employer of record and the member is the day-to-day manager;
- provides agency time sheets to the member and orients the member to the time sheet submission process, including how frequently time sheets must be completed;

- receives and processes attendant time sheets;
- sends new attendants within the required time frame to interview at the member's request; and
- orients the member to the agency's attendant evaluation process, including forms and the schedule for evaluating attendants.

5413 Member Responsibilities

The member or designated representative (DR) is responsible for most of the day-to-day management of the attendant's activities, beginning with interviewing and selecting the person who will be the attendant. To participate in the service responsibility option (SRO), the member must be capable of performing all management tasks as described below, or may identify a DR to assist or perform those management tasks on the member's behalf.

The member is responsible for:

- choosing the SRO service delivery option;
- choosing the SRO service and support provider(s);
- meeting with the SRO support provider within 14 days of selecting the SRO;
- coordinating with the agency supervisor as part of the service planning process by:
- negotiating the type, frequency and schedule of quality assurance contacts;
- discussing any concerns about care management;
- requesting on-site assistance while orienting a new attendant, if desired; and
- negotiating to develop a back-up plan for when the attendant cannot come to work;
- selecting personal attendant(s) from candidates sent by the agency (including someone the person recommends to the agency supervisor or someone who has completed the agency pre-employment screening);
- informing the agency supervisor within 24 hours:
    - of the personal attendant selected;
    - if the attendant gives notice of his intention to quit;
    - if the attendant quits; or
    - if the member wants to dismiss the attendant;
- training the personal attendant on how to safely perform the approved tasks in the manner desired;
- supervising the personal attendant;
- ensuring the attendant only does the tasks authorized in the service plan and works only the number of hours authorized in the service plan;
- complying with agency payroll and attendance policies;
- evaluating the attendant's job performance at the time designated by the agency;
- reviewing, approving and signing agency employee time sheets after the attendant completes them;
- ensuring employee time sheets are submitted to the agency within the time frames designated by the agency;
- notifying the agency as soon as possible if the personal attendant will be absent and a substitute is needed;

- taking responsibility for liability risk if the member or attendant is injured while doing tasks under the member's training and supervision;
- using the following complaint procedures:
    - If the agency is not fulfilling the expected responsibilities, address those issues directly with the agency. If the agency and the member are not able to resolve the concerns/issues, the member should contact the managed care organization (MCO).
    - If concerns and issues are still not resolved, the member may select another agency. The member must contact the MCO to transfer from one agency to another. The MCO will make all necessary arrangements for the transfer.
- notifying the MCO and/or agency supervisor of any health or safety concerns or issues with the attendant (the member may, at any time, request a service planning team meeting); and
- notifying the MCO and agency supervisor if a change to either the Agency Option or consumer directed services is desired. A service planning team meeting will be held to plan for the change.

5420 Managed Care Organization Procedures

The service responsibility option (SRO) is not a different service; it is a service delivery option. All financial and non-financial eligibility criteria, including unmet need and "do not hire" policy, continue to apply for each program area. Unless otherwise stated in this section, managed care organization (MCO) procedures are not impacted by the member's choice of SRO. Complete all forms currently required. Continue to identify any caregivers who are currently providing for the member's needs.

5421 Initial Authorization of Services

The member's decision to receive services using the service responsibility option does not change the manner in which initial services are authorized. See Section 3300, Member Service Planning and Authorization, for specific information.

5422 Monitoring

All monitoring for service responsibility option (SRO) members is done by the managed care organization (MCO) according to the mandated schedule for its specific services. When health and safety issues arise, the MCO staff will:

- discuss the issues with the agency staff;
- talk to the member to determine if the issues can be resolved; and
- convene a service planning team meeting if the issue cannot be resolved.

Because the member now shares responsibility for service delivery, the MCO, in addition to other monitoring requirements, must monitor the member's:

- satisfaction with the SRO; and
- ability to comply with SRO requirements.

If it is evident that the member is having difficulty in the management of SRO responsibilities, the MCO staff must:

- consult the agency staff; and
- advise the member of the option to transfer back to the agency option.

5423 Procedures for Ongoing Members

Members must be offered the service responsibility option (SRO) by the managed care organization (MCO) annually, and may request a transfer to the SRO at any time. Additionally, the SRO must be presented to ongoing members at each annual reassessment or upon request. If the member is interested in transferring to the SRO, the member must sign Form 1582-SRO, Service Responsibility Option Roles and Responsibilities.

The MCO must ensure the member understands the responsibility he/she is assuming. Send Form H2067-MC, Managed Care Programs Communication, to the agency to advise it of the member's selection. Notify the agency the member will be contacting it for training. Request the agency to advise the MCO, using Form H2067-MC, when the transition planning is complete. Negotiate a start date with the member and the agency.

Section 6000 - Denials and Terminations

This section provides information, procedures and references pertaining to denial or termination of Medically Dependent Children Program (MDCP) waiver services for active members, along with adequate notice of member's rights and opportunities to due process.

42 Code of Federal Regulations (CFR) Part 431, Subpart E, governs fair hearing rights for Medicaid applicants and beneficiaries. In general, the managed care organization (MCO) must adhere to the federally-mandated 10-day adverse action period for adverse action, including denials and terminations related to MDCP services. However, 42 CFR § 431.213 specifies situations in which an adverse action period is not required. The agency may mail a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a beneficiary;

(b) The agency receives a clear written statement signed by a beneficiary that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;

(d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);

(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

(f) A change in the level of medical care is prescribed by the beneficiary's physician;

(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e) (7) of the Act; or

(h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days' notice requirements of § 483.12(a)(5)(i).

1 Texas Administrative Code (TAC) §353.1209, which is cited on Form H2065-D, Notification of Managed Care Program Services, is the basis for all STAR Kids case action.

6100 10-Day Adverse Action Notification

42 CFR §431.230 requires that the Health and Human Services Commission (HHSC) provide a notice to the member at least 10 calendar days before the action effective date. The member

must be given the full 10-day adverse action period to give him or her time to file an appeal or request a fair hearing, as described below:

> (a) If the agency mails the 10-day or 5-day notice as required under § 431.211 or §431.214 of this subpart, and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—
>
> (1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
> (2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.
>
> (b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

The MCO must calculate time periods related to adverse actions in accordance with instruction provided in §311.014 of the Code Construction Act. It specifies that:

> (a) In computing a period of days, the first day is excluded and the last day is included.
> (b) If the last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday.

The 10-day adverse action period is extended based on whether the 10th day of the period is a Saturday, Sunday or legal holiday. A legal holiday that falls in the middle of the 10-day adverse action period does not require the period to be extended. Legal holidays do not include holidays when HHSC offices are officially open, even with limited workforce.

The full adverse action period may be waived if the individual signs a statement to waive the adverse action period.

6110 Denial of Medical Necessity/Individual Service Plan

When a member is denied Medically Dependent Children Program (MDCP) services because he or she does not meet medical necessity criteria or does not have a valid individual service plan (ISP), the following chart depicts an example of the dates Program Support Unit (PSU) staff use when completing case actions.

Date Informed Eligibility Lost	Date Form H2065-D Sent	Current ISP End Date	10-Day Adverse Action Expiration Date	Form H2065-D Termination Date	Long Term Care (LTC) Portal Data Entry
April 10	April 12	May 31	April 22	May 31	None
May 20	May 21	May 31	May 31	May 31	None
May 20	May 22	May 31	June 1	June 30	ISP must be extended to June 30.

Date Informed Eligibility Lost	Date Form H2065-D Sent	Current ISP End Date	10-Day Adverse Action Expiration Date	Form H2065-D Termination Date	Long Term Care (LTC) Portal Data Entry
June 5	June 7	May 31	June 17	June 30	ISP must be extended to June 30.
June 22	June 24	May 31	July 4	July 31	ISP must be extended to July 31.

6120 Denial of Medicaid Eligibility

When a member is denied Medically Dependent Children Program (MDCP) services because he or she does not meet Medicaid eligibility, the following chart depicts an example of the dates Program Support Unit (PSU) staff use when completing case actions.

Actual Date of Medicaid Eligibility Denial	Date Program Support Unit Informed Eligibility Lost	Current Individual Service Plan (ISP) End Date	Date Form H2065-D Sent	Form H2065-D Termination Date	Long Term Care Portal Data Entry
12-31-2016	12-31-2016	5-31-2017	1-2-2017	12-31-2016	Individual Service Plan (ISP) must be corrected to 12-31-2016.
12-31-2016	10-31-2016	5-31-2017	11-2-2017	12-31-2016	ISP must be corrected to 12-31-2016.
12-31-2016	2-5-2017	5-31-2017	2-7-2017	12-31-2016	ISP must be corrected to 12-31-2016.

Note:

- If eligibility for Medicaid is reestablished with a gap of over four calendar months, this must be treated as an interest list release. The managed care organization (MCO) processes initial assessments.
- If eligibility for Medicaid is reestablished with a gap of four calendar months or less, the existing ISP- and STAR Kids Screening and Assessment Instrument (SK-SAI) used to determine medical necessity (MN) are still valid. If the ISP and SK-SAI MN have expired, the MCO is allowed to do a reassessment without penalty.

6130 Unable to Locate

When a member is denied Medically Dependent Children Program (MDCP) services because he or she cannot be located, the following chart depicts an example of the dates Program Support Unit (PSU) staff use when completing case actions.

Date Program Support Unit Informed	Current Individual Service Plan (ISP) End Date	Date Form H2065-D Sent	Form H2065-D Termination Date	Long Term Care (LTC) Portal Data Entry
12-31-2016	5-31-2017	1-2-2017	1-31-2017	Individual service plan (ISP) must be corrected to 1-31-2017.
5-3-2017	5-31-2017	5-5-2017	5-31-2017	None
5-25-2017	5-31-2017	5-27-2017	6-30-2017*	ISP must be corrected to 06-30-2017.
6-9-2017	5-31-2017	6-11-2017	6-30-2017	Managed care organization (MCO) should have submitted an ISP and medical necessity (MN) for 6-1-2017.

*The 10-day adverse action period expires after the end of the month.

6200 Program Support Unit Initiated Denials/Terminations

The following sections contain policy citations that must be included on Form H2065-D, Notification of Managed Care Program Services, when the denial or termination action is initiated by Program Support Unit (PSU) staff.

6210 Denial/Termination Due to Death

Upon learning of the death of a member, the Program Support Unit (PSU) must post Form H2067-MC, Managed Care Communication, to the managed care organization (MCO) via TxMedCentral within two business days of verification.

Form H1746-A, MEPD Referral Cover Sheet, must be sent to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist, if appropriate. PSU does not send a notice to the member's address or family. The effective date is the date of death.
PSU staff upload the Form H2067-MC and Form H1746-A to HHS Enterprise Administrative Record Tracking (HEART).

If the member was receiving Supplemental Security Income (SSI) and the eligibility records reflect that SSI has been denied, PSU must use the same effective date of denial as the SSI denial date. If the eligibility records reflect SSI is still active, PSU must contact the Social Security Administration to notify it of the date of the member's death.

If a member's Medicaid eligibility has been denied due to death in the Texas Integrated Eligibility Redesign System (TIERS), the appropriate entries must be made to end enrollment in the Long Term Care (LTC) Portal.

Services must be terminated once death of the member has been confirmed by PSU via:

- TIERS;
- obituaries in the local newspaper;
- contact with family or friends;
- notification from the MCO; or
- other reliable sources.

A 10-day adverse action period is not required for death denials.

6220 Denial/Termination Due to Residence in a Nursing Facility

The process for members residing in a nursing facility (excluding Truman Smith*) is as follows:

- For members enrolled in STAR Kids, the enrollment remains open while a member resides in a nursing facility. For members with supplemental security income (SSI) or SSI-related Medicaid, the member remains enrolled in STAR Kids but loses eligibility for Medically Dependent Children Program (MDCP) services. For members without SSI or SSI-related Medicaid (i.e., Medical Assistance Only (MAO) members), loss of MDCP eligibility due to nursing facility residence will result in loss of Medicaid eligibility.
- For members enrolled in the MDCP, the managed care organization (MCO) notifies the Program Support Unit (PSU) within 14 calendar days following the 90th day that the member is not returning to the community when a member resides in a nursing facility for 90 days or more. The MCO sends this notice to the PSU by posting Form H2067-MC, Managed Care Programs Communications, in TxMedCentral.
- The PSU denies STAR+PLUS Home and Community-Based Services (HCBS) Program services by the end of the month in which the 90th day occurred by:
    - sending the member Form H2056-DSK, Notification of STAR Kids Managed Care Program Services;
    - posting the form on TxMedCentral in the MCO's STAR Kids folder;
    - sending to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form 2065-D, for Medical Assistance Only MDCP members; and
    - uploading Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

*Members enrolled in STAR Kids who enter the Truman Smith nursing facility or a state veteran's home are excluded from STAR Kids. STAR Kids and MDCP eligibility must be denied.

6230 Denial/Termination Due to Member Request

When the Program Support Unit (PSU) has been notified a member no longer wants waiver services, within two business day of becoming aware the member no longer wants services, PSU staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;

- post the form on TxMedCentral in the managed care organization (MCO's) STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

6240 Denial/Termination of Financial Eligibility

A member's continued receipt of STAR Kids services is dependent on financial eligibility determined by Supplemental Security Income (SSI) or Medical Assistance Only (MAO) program requirements.
The member is notified of denial of financial eligibility by either Social Security Administration (SSA) staff for SSI or Medicaid for the Elderly and People with Disabilities (MEPD) staff for MAO. The individual may appeal the financial denial using SSA or MEPD processes, as appropriate. Within two business days, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the managed care organization's (MCO's) STAR Kids folder;
- send to MEPD Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, MDCP members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

Notification can come from:

- monthly reports;
- Enrollment Resolution Services (ERS);
- a managed care organization; or
- other reliable sources.

The chart below describes how to proceed if financial eligibility is denied.

When the individual is denied SSI:	**When the individual is denied MAO:**
• disenrollment from the STAR Kids program will occur effective the last date of Medicaid eligibility, which is usually the last day of the current or following month. • the right to appeal to SSA is available to the individual. • the individual can contact the local HHSC office to request other long-term services and supports (for example, Community Attendant Services, Family Care, Title XX programs or state-funded programs).	• disenrollment from the STAR Kids program will occur effective the last date of Medicaid eligibility, which is usually the last day of the current or following month. • the right to appeal to MEPD is available to the individual. • the individual can contact the local HHSC office to request other long-term services and supports (for example, Community Attendant Services, Family Care, Title XX programs or state-funded programs).

When the individual is denied SSI:	When the individual is denied MAO:
• depending on the availability of local services, the individual may be placed on the interest list if Medicaid eligibility cannot be established according to the date of the request.	• depending on the availability of local services, the individual may be placed on the interest list if Medicaid eligibility cannot be established according to the date of the request.

For SSI members, the termination date must match the SSA termination date.
For MAO members, the termination date must match the MEPD MAO denial date. This is true even if the MAO denial date is in the past when the PSU becomes aware of the denial.

6250 Denial/Termination of Medical Necessity

Medically Dependent Children Program (MDCP) waiver services must be denied/terminated when the member's Medical Necessity (MN) is denied. Within two business days, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the managed care organization's (MCO's) STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) MDCP members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

Notification can come from:

- the Monthly individual service plan (ISP) Expiring Report;
- Enrollment Resolution Services (ERS);
- a Managed Care Organization (MCO); or
- other reliable sources.

The MN status of "MN Denied" in the Long-term Care (LTC) Portal is the period when the MDCP waiver applicant's/member's physician has 14 calendar days to submit additional information. Once an STAR Kids Screening and Assessment Instrument (SK-SAI) MN status is in "MN Denied" status, several actions may occur:

- MN Approved: The status changes to "MN Approved" if the Texas Medicaid & Healthcare Partnership (TMHP) doctor overturns the denial because additional information is received;
- Overturn Doctor Review Expired: The status changes to "Overturn Doctor Review Expired" when the 14 calendar day period for the TMHP doctor to overturn the denied MN has expired. No additional information was submitted for the doctor review. The denied MN remains in this status unless a fair hearing is requested; or
- Doctor Overturn Denied: The status changes to "Doctor Overturn Denied" when additional information is received but the TMHP doctor does not believe the information

submitted is sufficient to approve an MN. The denied MN remains in this status unless a fair hearing is requested.

The PSU specialist must not mail Form H2065-D to deny the MDCP waiver case until after 14 calendar days from the date the "MN Denied" status appears in the LTC Portal. The PSU specialist must meet initial certification and annual assessment time frames unless the time frames cannot be met due to the pending MN status. All delays must be documented.

6260 Denial/Termination Due to Inability to Locate the Member

The Medically Dependent Children Program (MDCP) waiver must be denied/terminated when the Program Support Unit (PSU) specialist is notified that a member cannot be found. Within two business days, the PSU specialist must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the managed care organization's (MCO's) STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) MDCP members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

Notification can come from:

- monthly reports;
- Managed Care Operations;
- a managed care organization; or
- other reliable sources.

6270 Denial/Termination Due to Failure to Meet Other Waiver Requirement

Use this denial citation if the individual does not meet a waiver requirement mentioned in Section 6210 through Section 6260. For example, this citation would be used if the individual applying for services does not require at least one waiver service. Within two business days, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the managed care organization's (MCO's) STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) MDCP members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

6280 Denial/Termination for Other Reasons

Use this citation if initiating denial/termination for a reason not covered in Section 6210 through Section 6270. Within two business days, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the managed care organization's (MCO's) STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

Notification can come from:

- monthly reports;
- Enrollment Resolution Services (ERS);
- a managed care organization; or
- other reliable sources.

6300 Denial/Termination Initiated by the Managed Care Organization

Section 6310 through Section 6370 contains policy citations that must be included in denial notifications when the action is initiated by managed care organization (MCO) staff. Within two days of the notification by the MCO, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the MCO's STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for medical assistance only (MAO) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

6310 Denial/Termination Due to Threats to Health and Safety

The managed care organization (MCO) and provider staff must take special precautions when an applicant's or member's comments or behavior appears to be threatening, hostile or of a nature that would cause concern for the safety of the applicant/member, an MCO-contracted provider or an MCO employee. If an applicant exhibits such behavior, the staff member must immediately notify his/her manager.

The Health and Human Services Commission (HHSC) reviews these situations on a case-by-case basis and determines the most appropriate action to be taken. If the applicant's/member's safety may be at risk, the MCO must follow current policy regarding notification to the Department of Family and Protective Services (DFPS). If the staff member believes there is a potential threat to others, HHSC management should determine the best method for notifying

the MCO and/or the contracted provider and for addressing the applicant's/member's needs without placing an MCO/provider staff member at risk.

Within two business days of the notification by the MCO, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the MCO's STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form 2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

The 10-day adverse action notification period does not apply in this situation.

6320 Denial/Termination Due to Hazardous Conditions or Reckless Behavior

When there is no immediate threat to the health or safety of the service provider, but the situation, member or someone in the member's home is hazardous to the health and safety of the service provider, appropriate documentation of denial is essential. For example, a situation where the member has a large dog that may bite if let loose could be resolved if the member or a neighbor or family member will agree to restrain the dog during times of service delivery.

However, if the provider shows up on numerous occasions at the designated time and the dog is loose and the provider has documented a substantial pattern of being unable to deliver services due to this, services could be terminated.

Similarly, if there are illegal drugs in the member's home used by the member or others, the service provider may not be in immediate danger, yet the situation still poses a threat. It is imperative that all available interventions are presented and the opportunity offered for the member to get rid of the illegal drugs and/or users, and agree to refrain and not allow the illegal drug use to resume. The managed care organization should convene an interdisciplinary team meeting if the illegal drug usage occurs again, and the member must be warned in writing of the potential loss of services for allowing this activity to continue.
Within two business days of the notification by the managed care organization, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the managed care organization (MCO's) STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

The 10-day adverse action notification period does not apply in this situation.

6330 Denial/Termination Due to Harassment, Abuse or Discrimination

A substantial demonstrated pattern of verbal abuse or discrimination must be clearly established and documented by the managed care organization (MCO) before services can be denied for either of these reasons. This means multiple occurrences of the inappropriate behavior, which have been followed up with face-to-face discussions with the member and/or his/her family or legal representative, explaining that the MCO does not condone discrimination, harassment and/or verbal abuse.

Appropriate interventions must be sought. This may include counseling, referral to other case management agencies and possibly changes to the individual service plan, such as attending Day Activity and Health Services for nursing.

There must be meetings of the Health and Human Services Commission (HHSC) staff that include outside agencies, when appropriate, such as the Department of Family and Protective Services' (DFPS) Child or Adult Protective Services. The results must be documented in letters sent to the member that offer an opportunity to stop the behavior, with clear indication that failure may result in loss of service. Copies of written warnings must be sent to all who attend the meetings and a copy must be retained in the case file.

If the situation persists and results in an inability to deliver services, the MCO may request disenrollment from HHSC. After HHSC approves the disenrollment, HHSC notifies the PSU supervisor via email. PSU sends Form H1746-A, MEPD Referral Cover Sheet, to Medicaid for the Elderly and People with Disabilities (MEPD), if appropriate.

Within two business days of the notification from the HHSC staff, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the MCO's STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

The 10-day adverse action notification period does not apply in this situation.

If the denial/termination is being considered due to verbal abuse or harassment of the service provider, HHSC must determine if this behavior is directly related to the individual's disability. If the member produces a letter from his physician indicating the behavior stems from the member's disability, services cannot be denied for this reason. Appropriate interventions to ensure service delivery as noted above should still be pursued.

6340 Denial as a Result of Exceeding the Cost Limit

The managed care organization (MCO) must consider all available support systems in determining if the waiver is a feasible alternative that ensures the needs of the applicant are adequately met. If the waiver is not a feasible alternative, the MCO must notify the Program Support Unit (PSU) of the denial and maintain appropriate documentation to support the denial.

The MCO's documentation of this type of denial is based on the inadequacy of the plan of care, including both waiver and non-waiver services, to meet the needs of the individual within the cost limit.

If the individual service plan (ISP) is over the cost limit, within two business days of receipt of the ISP, the PSU staff must:

- send the member Form H2065-D, Notification of Program Services;
- post the form on TxMedCentral in the MCO's STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

6350 Denial/Termination Due to Failure to Comply with Mandatory Program Requirements and Service Delivery Provisions

If the member repeatedly and directly, or knowingly and passively, condones the behavior of someone in his home and thus refuses more than three times to comply with service delivery provisions, services may be denied/terminated. Refusal to comply with service delivery provisions includes actions by the member or someone in the member's home that prevent determining eligibility, carrying out the service plan or monitoring services. Within two business days of the notification, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the MCO's STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

6360 Denial/Termination Due to Failure to Pay

If the member refuses to pay a required copayment, room and board (R&B) payment or Qualified Income Trust (QIT) payment, the Medically Dependent Children Program (MDCP) waiver must be denied. After notification by the managed care organization (MCO), within two business days of notification, the Program Support Enrollment (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the MCO's STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

The 10-day adverse action period does apply in this situation.

6370 Denial/Termination Due to Other Reasons

Use this denial/termination citation if initiating denial for a reason not covered above. After notification by the managed care organization (MCO), within two business days of notification, the Program Support Unit (PSU) staff must:

- send the member Form H2065-D, Notification of Managed Care Program Services;
- post the form on TxMedCentral in the MCO's STAR Kids folder;
- send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Coversheet, and a copy of the Form H2065-D, for Medical Assistance Only (MAO) Medically Dependent Children Program (MDCP) members; and
- upload Forms H2065-D, Notification of Program Services and H1746-A to the HHS Enterprise Administrative Record Tracking (HEART).

Section 7000 - Complaint, Appeal and Fair Hearing Procedures

7100 Managed Care Organization Procedures

The managed care organization (MCO) must develop, implement and maintain a member complaint and appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 Code of Federal Regulations (CFR) §431.200; 42 CFR Part 438, Subpart F, Grievance System; and the provisions of 1 Texas Administrative Code (TAC) Chapter 357, relating to Medicaid managed care organizations.

The MCO's complaint and appeal system must include:

- a complaint process;
- an internal appeal process; and
- access to the Health and Human Services Commission fair hearing process.

7110 Managed Care Organization Complaint Procedures

The Health and Human Services Commission's (HHSC) STAR Kids Managed Care Contract, Attachment A, defines a complaint as:

> "an expression of dissatisfaction expressed by a Complainant, orally or in writing to the managed care organization (MCO), about any matter related to the MCO other than an Action. As provided by 42 C.F.R. § 438.400, possible subjects for Complaints include the quality of care of services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid member's rights."

The complaint procedure does not apply to situations described in "Appeal Procedures".

When members want to file a complaint, they must first contact the MCO, following procedures specified in the MCO's member handbook. The MCO must provide designated member advocates to:

- assist members in using the complaint system:
- assist members in writing or filing a complaint; and
- monitor the complaint throughout the process until the issue is resolved.

In addition to filing complaints with the MCO, a STAR Kids member may file complaints with the state. If a STAR Kids member contacts the MCO or any HHSC employee with a complaint regarding an agency licensed by HHSC, or any other state agency, the member is referred to 1-800-458-9858 to file a regulatory complaint. If the complaint is initially received by HHSC, HHSC will inform the MCO of the complaint.

Members may also call the HHSC Ombudsman's Managed Care Assistance Team at 1-866-566-8989 for assistance filing a complaint not related to licensure issues.

7120 Managed Care Organization Internal Appeal Procedures

The Texas Health and Human Services Commission's (HHSC) STAR Kids Managed Care Contract, Attachment A, defines an appeal as the formal process by which a member or his or her authorized representative requests a review of the managed care organization's (MCO's) action. An action is:

- the denial or limited authorization of a requested Medicaid service, including the type or level of service;
- the reduction, suspension or termination of a previously authorized service not caused by loss of eligibility;
- denial in whole or in part of payment for service;
- failure to provide services in a timely manner;
- failure of an MCO to act within the time frames set forth in the contract and 42 Code of Federal Regulations (CFR) §438.408(b); or
- for a resident of a rural area with only one MCO, the denial of a Medicaid member's request to obtain services outside of the network.

The member may file an internal appeal by contacting the MCO following the procedures specified in the MCO's member handbook. The MCO is contractually required to regard any oral or written expression of dissatisfaction or disagreement related to the actions listed above as an appeal. The MCO must provide a designated member advocate to assist the member in filing an appeal. The advocate must also assist members or authorized representatives by monitoring the appeal throughout the process until the issue is resolved.

During the internal appeal process, the MCO must provide the member or an authorized representative a reasonable opportunity to present evidence and any allegations of fact or law in person, as well as in writing. The MCO must inform the member or the authorized representative of the time available for providing this information.

The MCO must provide the member and his or her authorized representative the opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents considered during the appeal process.

As required by 42 CFR §438.420, the MCO must continue the individual's benefits pending the outcome of the internal appeal if all the following criteria are met:

1. The member or his or her authorized representative files the internal appeal timely as defined in the STAR Kids Managed Care Contract:
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The original period covered by the original authorization has not expired; and
5. The member requests an extension of the benefits.

7121 Expedited Managed Care Organization Internal Appeals

In accordance with 42 Code of Federal Regulations §438.410, and STAR Kids Managed Care Contract, Attachment B-1, Section 8.1.29.3, the managed care organization (MCO) must

establish and maintain an expedited review process for service-related internal appeals when the MCO determines (for a request from a member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health. The MCO must follow all internal appeal requirements for standard member internal appeals as set forth in the STAR Kids Managed Care Contract, Attachment B-1, Section 8.1.29.2, except where differences are specifically noted. The MCO must accept oral or written requests for expedited internal appeals.

After the MCO receives a request for an expedited internal appeal, the MCO must notify the member or his or her authorized representative of the outcome of the expedited internal appeal request within three business days. However, the MCO must complete investigation and resolution of an internal appeal relating to an ongoing emergency or denial of continued hospitalization:

- in accordance with the medical or dental immediacy of the case; and
- not later than one business day after receiving the member's request for an expedited internal appeal.

Members must exhaust the MCO's expedited internal appeal process before making a request for an expedited state fair hearing.

Except for an internal appeal relating to an ongoing emergency or denial of continued hospitalization, the time frame for notifying the member of the outcome of the expedited internal appeal may be extended up to 14 calendar days if the member requests an extension or the MCO shows (to the satisfaction of the Health and Human Services Commission (HHSC), upon HHSC's request) there is a need for additional information and how the delay is in the member's interest. If the time frame is extended, the MCO must give the member written notice of the reason for delay if the member did not request the delay.

If the determination is adverse to the member, the MCO must follow the procedures relating to the notice in the STAR Kids Managed Care Contract, Attachment B-1, Section 8.1.29.5. The MCO is responsible for notifying the member of his or her right to access a state fair hearing from HHSC. The MCO is responsible for providing documentation to the state and the member, indicating how the determination was made, prior to HHSC's fair hearing.

The MCO is prohibited from discriminating or taking punitive action against a member or his/her representative for requesting an expedited internal appeal. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's request.

If the MCO denies a request for expedited resolution of an internal appeal, the MCO must:

- transfer the appeal to the time frame for standard internal resolution; and
- make a reasonable effort to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

7200 State Fair Hearing Procedures for Medically Dependent Children Program

7210 Program Support Unit Procedures

When a request for a state fair hearing related to Medically Dependent Children Program (MDCP) eligibility is received from an applicant or member, orally or in writing, Program Support Unit (PSU) staff must refer the request to the Health and Human Services Commission Appeals Division within five calendar days from the date of the request. Upon receipt of the fair hearing request, the PSU specialist completes Form H4800, Fair Hearing Request Summary. The PSU specialist either:

- sends the form to the regional data entry representative (DER) within **three** calendar days of the request for a hearing, which allows the DER two days to enter the information into the Texas Integrated Eligibility Redesign System (TIERS); or
- enters the request for a fair hearing into TIERS, ensuring it is entered within five calendar days from the date of the request.

The Form H4800, Fair Hearing Request Summary, records the names, titles, addresses and telephone numbers of all persons, or their designees, who should attend the hearing. For appeal issues related to service delivery, enter the names of the designated managed care organization (MCO) staff and the designated backup. PSU staff should contact the MCO if there is doubt as to who should be listed on Form H4800.

Depending on the issue being appealed, the following staff must attend:

- MCO (whenever possible, this should be the individual who completed the assessment) and Texas Medicaid & Healthcare Partnership (TMHP) (for medical necessity denials);
- MCO (for denials of individual service plans (ISPs) over the cost ceiling); and
- Medicaid for the Elderly and People with Disabilities (MEPD) (for financial denials).

When PSU staff complete Form H4800 all questions in Section 3, Appellant Details Programs, must be answered. In Subsection D, Summary of Agency Action and Citation, staff must always answer “No” to the question, “Is there a good cause for non-timely?” as this question applies only to Texas Works programs.

PSU staff must indicate the ISP begin and end dates, as applicable, in Section 3.D., Summary of Agency Action and Citation. The begin and end dates must also be mentioned during the state fair hearing so the hearings officer is aware of when the ISP year ends when rendering a hearing decision regarding the MDCP waiver denial.

The Form H4800 format follows the data entry screens. See the Form H4800 instructions for more specific directions for completion and transmittal.

7211 Designated Data Entry Representative Procedures

Within two calendar days of receipt of Form H4800, Fair Hearing Request Summary, the data entry representative (DER) enters the information into the Hearings and Appeals section of the

Texas Integrated Eligibility Redesign System (TIERS). When entry of all information is complete, the system assigns the appeal identification (ID) number. The DER notes the appeal ID number on the bottom of the form and in the designated space on the front of the form, and sends a copy back to the PSU specialist.

7212 Fair Hearings and Appeals Procedures

The Texas Integrated Eligibility Redesign System (TIERS) generates a hearing packet, which includes:

- Form H4803, Notice of Hearing; and
- Form H4800, Fair Hearing Request Summary.

The Program Support Unit (PSU) specialist and his or her supervisor receive a copy of Form H4800 and Form H4803, identifying the hearings officer assigned to the appeal and the date, time and location of the hearing. PSU staff are not expected or required to attend state fair hearings.

7213 Evidence Packet

All related documentation necessary to support the determination on appeal must be uploaded into the State Portal and mailed to the appellant at least 10 business days prior to the hearing. Each entity involved in the action taken is responsible for preparing its evidence packet, uploading it to the State Portal, and forwarding it to the appellant. All documentation must be neatly and logically organized, and all pages numbered.

The following are examples of documentation that may be submitted as evidence and the entity responsible for uploading that information to the State Portal:

- Managed care organization (MCO):
    - MCO policy handbook, STAR Kids Handbook and/or STAR Kids Managed Care Contract/STAR Kids Managed Care Manual;
    - summary of events;
    - other documentation supportive of the determination, such as documentation of telephone calls and visit summaries; and
    - copies of the signed Form 2603, STAR Kids Individual Service Plan (ISP) Narrative, and all relevant attachments;
- Medicaid for the Elderly and People with Disabilities (MEPD) Centralized Representation Unit (CRU):
    - documentation supportive of the financial determination, including official documentation forms and telephone calls; and
    - a copy of the original signed denial form;
- Texas Medicaid & Healthcare Partnership (TMHP):
    - a copy of the STAR Kids Screening and Assessment Instrument (SK-SAI); and
    - other documentation supporting the determination; and
- Program Support Unit (PSU) — a copy of the original signed Form H2065-D, Notification of Managed Care Program Services (if available, use the signed copy of the form returned by the applicant/member when the state appeal was filed).

7214 Fair Hearing Request Summary (Addendum)

After the data entry representative (DER) or Program Support Unit (PSU) specialist has added information from Form H4800, Fair Hearing Request Summary, into the Texas Integrated Eligibility Redesign System (TIERS), PSU may learn of subsequent changes such as address changes, withdrawal forms or additional supporting documents needed for a state fair hearing. When this occurs, PSU staff complete Form H4800-A, Fair Hearing Request Summary (Addendum) with the updated information and submit it to the designated DER who will check TIERS to identify if a hearings officer has been assigned to the case. In the event the updates need to be communicated to the hearings officer, PSU staff complete and forward Form H4800 to the DER.

If a hearings officer is not yet assigned, the DER must wait until one is assigned to send the additional information. When sending information, the DER completes the following activities according to the situation:

- When PSU staff submit Form H4800-A or Form H4800 to the DER, the DER sends the form(s) directly to the hearings officer's email address with the appeal ID number in the subject line.
- If the PSU staff submission to the DER includes additional supporting documentation for a state appeal, the DER not only emails Form H4800-A to the assigned hearings officer, but also uploads the supporting documentation directly into the State Portal. The email sent by the DER must include the appeal ID number in the subject line, as referenced above, and inform the hearings officer that supporting documentation listed in Section 2 of Form H4800-A has been uploaded to the State Portal.

PSU staff and the DER must follow current time frames and procedures to ensure supporting documentation is uploaded into the State Portal no later than 10 calendar days prior to the state fair hearing date.

7220 Special Procedures for Cases: Medicaid for the Elderly and People with Disabilities or Texas Works-Determined Financial Eligibility

7221 Centralized Representation Unit

The Health and Human Services Commission (HHSC) Medical and Social Services (MSS) maintains a Centralized Representation Unit (CRU) to handle all hearings for Medicaid for the Elderly and People with Disabilities (MEPD) and Texas Works (TW) staff. CRU replaces the MEPD specialist in specific steps related to the denial of MEPD applications and ongoing cases. The CRU:

- represents HHSC MSS in state fair hearings, which includes both TW and MEPD;
- completes and implements all TW/MEPD case actions based on fair hearing decisions for all appeals initiated by the CRU; and
- coordinates actions required with TW/MEPD and program support unit (PSU) staff.

PSU staff must coordinate all state appeals involving TW/MEPD-related eligibility with CRU. This includes Medically Dependent Children Program (MDCP) waiver cases. The procedures in Section 7222, Program Support Unit Procedures, must be used to coordinate state appeal actions with CRU in cases for which TW or MEPD staff determine financial eligibility. All

correspondence on state appeals will go to the CRU supervisor and the CRU administrative assistant.

7222 Program Support Unit Procedures

Program Support Unit (PSU) staff is responsible for completing Form H4800, Fair Hearing Request Summary, to file the appeal through the Texas Integrated Eligibility Redesign System (TIERS) when an applicant/member requests a state fair hearing. For state appeals that involve the Centralized Representation Unit (CRU), the method in which the form is completed depends on the action being appealed. PSU staff must determine if the appealed action is a:

- MDCP waiver denial (excludes denials based on a Texas Works (TW)/Medicaid for the Elderly and People with Disabilities (MEPD) denial action); or
- TW/MEPD financial denial (denials based on a TW/MEPD denial action).

If the appealed action is related to a Medically Dependent Children Program (MDCP) waiver denial based on an eligibility factor other than financial, PSU staff complete Form H4800-D, entering the managed care organization (MCO) contact as the agency representative.

If the appealed action is related to an MDCP waiver denial based on a TW/MEPD financial denial, PSU staff complete Form H4800 and enter the name of the PSU staff person who will appear at the fair hearing as the agency representative. This information must be entered through the MOR Search function for the PSU staff person to receive the hearing information.

For members requesting continued benefits and who are part of the Medical Assistance Only eligibility group, when Form H4800 is sent to the designated data entry representative, PSU staff sends an email notification regarding the request for a state fair hearing to CRU. PSU staff send the email to the HHSC Office of Eligibility Services (OES) Fair Hearings mailbox, which can be found in the Outlook Global Address List search box by typing HHSC OES Fair Hearings. In the subject line of the email, include the following: Request for Continued Benefits-Appeal ID-XXXXXXX. In an attachment to the email, staff must also include a copy of the notification form sent to the applicant or member.

The email must include:

- applicant's/member's name;
- Medicaid number (if available);
- type of service (MDCP waiver); and
- specific information requesting TW/ MEPD financial case remain active/open during the state fair hearing, if the member appealed in a timely manner and requested continued benefits. For example, the financial case may need to remain open pending an appeal decision regarding medical or functional eligibility.

When an MDCP waiver denial fair hearing decision is rendered by the hearings officer, the PSU staff is notified via email of the decision by the hearings officer. Based on the hearing decision, PSU staff determines the appropriate action for the waiver according to program-specific time frames. For more information, refer to Section 7500, Hearing Decision Actions.

PSU staff may need to coordinate effective dates of reinstatement with CRU and must send an email to the HHSC OES Fair Hearings mailbox, and include a Form H1746-A, MEPD Referral

Cover Sheet. PSU staff report the implementation of the hearing decision through Texas Integrated Eligibility Redesign System (TIERS), Decision Implementation.

If a member appeals a Medicaid denial issued by the TW or MEPD program, the CRU enters the fair hearing request in TIERS and notifies PSU the applicant/member appealed the Medicaid denial by sending an email to the PSU supervisor and backup designee. When notifying the PSU, CRU staff use the following subject line: "URGENT: STAR Kids member appealed financial denial of MDCP program. MCO Plan Code XX (if available)". The CRU processes the fair hearing request of the Medicaid denial following established procedures. CRU does not list the MCO or PSU staff on the fair hearing request.

Within two business days of receiving the notice the applicant or member is appealing the financial denial, the PSU contacts the applicant or member, or his or her authorized representative, to determine whether he or she wants to appeal MDCP program denial. If so, PSU staff processes the fair hearing request following established procedures.

For TW/MEPD appeals, once the appeal decision regarding the MEPD financial case is rendered by the hearings officer, CRU must notify PSU staff by sending an email to the PSU supervisor and backup designee of the hearing decision, including decisions that are sustained, reversed or withdrawn. Based on the hearing decision, PSU staff determines the appropriate action for the MDCP waiver. The email sent by CRU includes:

- applicant's/member's name;
- TIERS case number; and
- a copy of the hearing decision.

If Medicaid eligibility will be denied, the CRU includes the effective date of the Medicaid denial in the email. If Medicaid eligibility will be reinstated, the PSU must send the CRU an email with a Form H1746-A to the HHSC OES Fair Hearings mailbox, which can be found in the Outlook Global Address List search box by typing HHSC OES Fair Hearings, indicating all other eligibility criteria are in place and Medicaid needs to be reestablished. The CRU will respond to the PSU by sending an email to the PSU supervisor and backup designee with the effective date of Medicaid eligibility.

PSU staff must not put an applicant/member back on the MDCP waiver interest list while a TW/MEPD denial is in the state appeal process. PSU staff must take appropriate action to certify or deny the case, or resume services once the TW/MEPD hearing decision is rendered. The individual may choose to be added back to the MDCP waiver interest list once staff denies the waiver.

7230 Evidence Packet and Hearing Decision

7231 Uploading the Appeals Evidence Packet into the State Portal

All evidence packets must be uploaded into the State Portal using the process described below. The regional data entry representative (DER) uses Form H4800-A, Fair Hearing Request Summary (Addendum), to submit all supporting documentation (also referred to as the appeals packet) to the hearings officer. The appeal identification number assigned by Texas Integrated Eligibility Redesign System (TIERS) must be written on the top of Form H4800-A.

At least **12 business days** prior to the fair hearing date, the Program Support Unit (PSU) specialist must:

- scan the documentation;
- save the document by either allowing the default document name or entering a name of the user's choosing;
- retrieve the scanned document and attach it to an email; and
- send the document to the regional DER.

Within **two business days** after receipt, the DER must:

- save the attachment to the appropriate network drive, as assigned by regional management;
- go into the State Portal and select the Appeals tab, without launching TIERS;
- ensure the appeal has been entered in TIERS (this requirement must be met before the next step can be completed);
- select Hearing Evidence Packets Upload and enter the Appeal ID;
- select Document Type: Agency Evidence Packet (items entered in any other selection will not be included in the evidence packet);
- select Validate;
- check the details to ensure the right person has been selected;
- browse for the document; and
- select Upload.

Users who make mistakes they are unable to reverse may contact the state office Document Maintenance manager to assist in correcting the error and uploading the appropriate information.

7232 Presentation of the Evidence Packet

The Texas Integrated Eligibility Redesign System (TIERS) generates a hearing packet that includes Form H4803, Notice of Hearing, and Form H4800, Fair Hearing Request Summary. The Program Support Unit (PSU) staff and his/her supervisor receive a copy of Form H4800 and Form H4803, identifying the hearings officer assigned and the date, time and location of the hearing. PSU staff are not expected or required to attend state fair hearings.

Documentation contained in the evidence packet is not considered in the hearing decision unless the packet is offered and admitted into evidence. To accomplish this requirement, the agency representative must present the packet, ask that it be admitted as evidence and summarize what the packet contains.

Example: "I want to offer the following packet as evidence in the appeal filed on the behalf of Ned Flanders. Pages 1-10 contain information relating to the completion of Form 2603, STAR Kids, Individual Service Plan (ISP) Narrative. Pages 11-15 contain policy from the STAR Kids Handbook that relates directly to the issue in question. Pages 16-20 contain documents signed by the applicant related to individual rights. Page 21 contains Form H2065-D, Notification of Managed Care Program Services, which was mailed to the applicant on March 2, 2016."

The hearings officer then asks for objections and admits the documents into evidence. If any documents are not admitted, the hearings officer explains the reasons for excluding the

material. Any documents admitted by the hearings officer are considered when a decision is rendered.

7233 Hearing Decision

After the hearing, the hearings officer sends a hearing decision to the appellant and copies to individuals listed on the H4800, Fair Hearing Request Summary, which includes PSU staff. If the determination on appeal is sustained, the PSU staff takes the appropriate action. If the member requested continued services during the state appeal period, the PSU follows procedures described in Section 7500, Hearing Decision Actions.

If the determination on appeal is reversed, the hearings officer specifies the corrective action to be taken and a 10-day time frame for completion of the action. The PSU specialist actions required by the hearings officer must be reported back through the Texas Integrated Eligibility Redesign System (TIERS), Decision Implementation, within the 10-day time frame designated by the hearings officer.

7300 Post Hearing Actions

7310 Action Taken on the Hearing Decision

The Program Support Unit (PSU) staff completes Form H4807, Action Taken on Hearing Decision, recording case actions taken and sends it to the designated data entry representative (DER). The PSU specialist must send Form H4807 within the time frame specified by the hearings officer to allow at least two days for the DER to enter the information into the system. If the action cannot be taken by the time frame designated by the hearings officer, Form H4807 is completed and sent to the supervisor and DER, providing the reason for the delay. Acceptable reasons are listed on the form; the begin delay date and end delay date must be included.

7400 Continuation of Services

7410 Continuation of Medically Dependent Children Program Waiver Services during a State Appeal

Medically Dependent Children Program (MDCP) waiver services must continue until the hearings officer issues a decision regarding the appeal of an active MDCP waiver member, if the appeal is filed by the effective date of the action pending the appeal. If a state appeal was requested by the effective date of the action, Program Support Unit (PSU) staff must promptly notify the managed care organization (MCO) by posting Form H2067-MC, Managed Care Programs Communications, to the MCO via TxMedCentral and uploading a copy of this form in the HHS Enterprise Administrative Record Tracking System HEART.

If the member requests continued benefits, MDCP waiver services must continue to be provided until the hearings officer renders a decision. The PSU includes this information in the Form H2067-MC posted on TxMedCentral.

If the hearings officer's decision will not be made until after the individual service plan (ISP) expiration date, PSU staff must extend the current ISP for four calendar months or until the

outcome of the state appeal is determined. PSU staff does not send Form H2065-D, Notification of Managed Care Program Services, to the member notifying of continued eligibility related to the reassessment action taken to continue services until the appeal decision is issued.

If a state appeal is initially dismissed and subsequently re-opened, the Health and Human Services Commission (HHSC) continues/restarts services pending the appeal outcome, if the member requests continued services. When the hearings officer sets a date for a new hearing, he/she, in effect, voids the prior hearing decision. Because services are continued until a decision is rendered, and the hearings officer is stating there is still a hearing to be held, HHSC continues/re-starts services again.

7420 Discontinuation of Medically Dependent Children Program Waiver Services during a State Fair Hearing

If a state fair hearing is not requested by the effective date of the action, Medically Dependent Children Program (MDCP) waiver services continue until the effective date of denial notated on Form H2065-D, Notification of Managed Care Program Services, which is usually the expiration date of the current individual service plan (ISP). The Program Support Unit (PSU) must complete Form H2067-MC, and process according to the following:

- For Medical Assistance Only (MAO) members, Form H2067-MC is:
    - posted to TxMedCentral to inform the managed care organization (MCO) MDCP waiver services must continue until the end of the ISP period or the Medicaid denial date, as notated on Form H2065-D; and
    - emailed to Enrollment Resolution Services (ERS) to disenroll from STAR Kids following the disenrollment policy effective the day immediately following the ISP expiration date for MAO MDCP members only.

- For Supplemental Security Income (SSI) members, Form H2067-MC should be posted to TxMedCentral to inform the MCO that MDCP waiver services should only continue until the effective date of the action, which is usually the expiration date of the ISP.

SSI members are still enrolled in a STAR Kids MCO and are still eligible for State Plan services, which include acute care and long-term services and supports, such as personal care services (PCS), day activity and health services (DAHS), and community first choice services (CFC).

7500 Hearing Decision Actions

7510 Sustained Appeal Decisions

When the hearings officer's decision sustains the denial of Medically Dependent Children Program (MDCP) waiver services, Program Support Unit (PSU) staff must:

- notify the member via telephone or letter (if the individual does not have a telephone) of the hearings officer's decision and the termination effective date;
- notify the managed care organization by posting Form H2067-MC, Managed Care Programs Communication, to TxMedCentral, to deliver services through the MDCP waiver termination effective date if services were continued during the state fair hearing process;

- terminate MDCP services by end dating the individual service plan (ISP) in the Texas Medicaid & Healthcare Partnership (TMHP) portal effective the MDCP termination effective date;
- send an email to the HHSC Office of Eligibility Services (OES) Fair Hearings mailbox, which can be found in the Outlook Global Address List search box by typing HHSC OES Fair Hearings, notifying the Centralized Representation Unit (CRU) of the hearings officer's decision and the termination effective date for non- Supplemental Security Income (SSI) recipients; and
- notify Enrollment Resolution Services (ERS) of the hearings officer's decision and the termination effective date for non-SSI recipients. ERS disenrolls non-SSI recipients from STAR Kids.

PSU must not send another Form H2065-D, Notification of Managed Care Program Services, to notify the member of the sustained denial.

7511 Sustained Decisions – Termination Effective Dates

When services are terminated at reassessment because the member does not meet eligibility criteria and services are continued until the state fair hearing decision is known, the Medically Dependent Children Program (MDCP) waiver termination effective date will vary depending on the following circumstances:

- In cases where the hearings officer's decision is 30 calendar days or more prior to the end of the individual service plan (ISP) in effect when the state fair hearing was filed, MDCP waiver termination is effective at the end of the ISP in effect at the time the state fair hearing was filed. See Example 1.
- When the hearings officer's decision date is less than 30 calendar days before the end of the ISP in effect when the state fair hearing was filed, the termination effective date is the end of the month that is 30 calendar days from the hearings officer's decision date (the date the order is signed). See Example 2.
- When the hearings officer's decision date is after the end of the ISP in effect when the state fair hearing was filed, and a new ISP was developed to continue services past the ISP end date until the appeal decision was made, the termination effective date is the end of the month that is 30 calendar days from the hearings officer's decision date. See Example 3.
- If the hearings officer assigns a specific medical necessity (MN) expiration date not equal to the last day of the month but after the end of the ISP in effect when the state fair hearing was filed, the termination effective date is the end of the month the hearings officer identified as the expiration month. See Example 4.
- When the hearings officer assigns a specific MN expiration date equal to the last day of the month, and this date is equal to or after the end of the ISP in effect when the state fair hearing was filed, the termination effective date is the end of that ISP period. See Example 5.
- If the hearings officer assigns a specific MN expiration date that is before the end of the MN in effect when the state fair hearing was filed, the termination effective date is the end of the month of the original MN expiration date. See Example 6.

Examples

Example	Conditions	Original MN/ISP Expiration Date	New Expiration Date	Hearings Officer Decision Date	Final MN/ISP Expiration Date
1	Hearings officer decision is more than 30 days from the original expiration date.	1/31/16	5/31/16	11/30/15	1/31/16
2	Hearings officer decision is less than 30 days from the original expiration date.	1/31/16	5/31/16	1/15/16	2/28/16
3	Hearings officer decision is greater than the original ISP expiration date and less than the new expiration date.	1/31/16	5/31/16	2/15/16	3/31/16
4	Hearings officer decision assigns a specific expiration date.	1/31/16	5/31/16	Hearings officer decision was for MN to expire on 2/15/16.	2/29/16
5	Hearings officer decision assigns a specific expiration date that occurs in the future.	1/31/16	5/31/16	Hearings officer decision was for MN to expire on 2/29/16.	2/29/16
6	Hearings officer decision assigns a specific expiration date that occurred in the past.	1/31/16	5/31/16	Hearings officer decision was for MN to expire on 12/31/15.	1/31/16

7520 Reversed Appeal Decisions

When the hearings officer's decision reverses the denial of a Medically Dependent Children Program (MDCP) waiver applicant or member, Program Support Unit (PSU) staff must:

- notify the managed care organization (MCO) via Form H2067-MC, Managed Care Programs Communication, that MDCP waiver services are to continue as directed in the hearings officer's decision and to request Form 2603, STAR Kids Individual Service Plan (ISP) Narrative;
- send Form H2065-D, Notification of Managed Care Program Services, within two business days to the:

    - member who was terminated at reassessment to notify him or her the denial determination was reversed and he is eligible for MDCP waiver services for the new individual service plan (ISP) year;
    - applicant who was denied at application to notify him of eligibility for MDCP waiver services;
    - MCO regarding applicants and members at reassessment of the MDCP waiver effective date; and
    - ERS staff regarding applicants and the MDCP waiver effective date and enrollment date; and
- ensure the ISP is registered or updated in the Long Term Care online portal with the correct effective dates; and
- send an email with a Form H1746-A, MEPD Referral Coversheet, to the HHSC Office of Eligibility Services (OES) Fair Hearings mailbox, which can be found in the Outlook Global Address List search box by typing HHSC OES Fair Hearings, notifying the Centralized Representation Unit (CRU) of the hearings officer's decision and the member meets all eligibility criteria for the MDCP waiver, for non-supplemental security income recipients. The CRU will respond to the PSU by sending an email to the PSU supervisor and backup designee with the effective date of Medicaid eligibility.

7521 Reversed Decisions – Effective Dates

When the hearings officer’s decision reverses the denial of Medically Dependent Children Program (MDCP) waiver eligibility, the MDCP waiver effective date for:

- reassessment is one day after the end of the individual service plan in effect when the state fair hearing was filed; and
- MDCP waiver denied at application is the first of the month following the hearings officer's decision.

When a fair hearing decision reverses a Program Support Unit (PSU) action but PSU staff cannot implement the fair hearing decision within the required time frame, PSU staff must complete the Implementation Delays screen in Texas Integrated Eligibility Redesign System (TIERS), Decision Implementation.

7522 New Assessment Required by Fair Hearing Decision

If the hearings officer’s final decision orders completion of a new STAR Kids Screening and Assessment Instrument (SK-SAI) assessment, the hearing is closed as a result of this ruling. Program Support Unit (PSU) staff must notify the member of the results of the new assessment on Form H2065-D, Notification of Managed Care Program Services. If the new assessments results in a denied medical necessity (MN), the member may appeal the results of the new assessment. If the member chooses to appeal, PSU staff must indicate in Section 3.D., Summary of Agency Action and Citation, of Form H4800, Fair Hearing Request Summary, that the new assessment was ordered from a previous fair hearing decision.

If the member requests a state fair hearing of the new assessment and services are continued, the managed care organization (MCO) continues services until the second fair hearing decision is implemented. For example, a Medically Dependent Children Program (MDCP) waiver member is denied medical necessity (MN) at an annual reassessment and requests a fair

hearing and services are continued. The MCO would continue services at the level the member was receiving prior to the MN denial. The hearings officer then orders a new MN assessment, which results in another MN denial. PSU staff send a notice to the member informing him of the MN denial. The member then requests another fair hearing and services are continued pending the second fair hearing decision. The MCO continues services at the same level services were continued prior to the first fair hearing. If the new assessment results in MN approval but a lower Resource Utilization Group (RUG) level and the member requests a fair hearing due to the lower RUG level, the MCO would continue services at the same level services were continued prior to the first fair hearing.

7523 Request to Withdraw an Appeal

An appellant or appellant representative must request to withdraw his appeal by sending written notice to the hearings office. The hearings office cannot accept an oral request to withdraw his or her appeal. If the appellant or appellant representative contacts Program Support Unit (PSU) staff regarding a withdrawal, PSU staff must advise the appellant or the appellant's representative the request to withdraw the appeal must be a written notice to the hearings office. If the appellant or appellant's representative sends a written request to withdraw to PSU staff, PSU staff must forward this written request to the hearings office. All requests to withdraw the hearing must originate from the appellant or appellant representative and must be made to the hearings office.

If the appellant or appellant's representative requests to withdraw his appeal within 14 calendar days of the fair hearing date, the hearings officer will notify PSU by phone or email and open the conference line to inform participants of the cancellation. If the appellant or appellant's representative requests to withdraw his state appeal more than 14 calendar days prior to the fair hearing date, the hearings officer will indicate the withdrawal in the Texas Integrated Eligibility Redesign System (TIERS) and will send a written notice to participants informing them of the fair hearing cancellation.

7600 Roles and Responsibilities of HHSC Hearing Officers

The Health and Human Services Commission hearing officer:

- notifies all persons listed on Form H4800, Fair Hearing Request Summary, of the date, time and location of the hearing;
- prepares a final order disposing of a case through withdrawal and sends copies of this order to the appellant and PSU upon written notification from the appellant to withdraw a state appeal;
- conducts the hearing;
- uses the Texas Medicaid & Healthcare Partnership (TMHP) nurse to determine whether any new medical information introduced at the hearing meets the medical necessity (MN) criteria for nursing facility care;
- reserves the right to hold a case open after a hearing pending medical review by TMHP physicians;
- submits a written request for medical review to TMHP for all new medical information presented at a hearing in situations where the TMHP nurse determines the new medical information presented does not meet the MN criteria;
- renders a decision; and

- sends a written copy of all hearing decisions to the member/applicant, TMHP and the PSU staff within five days of making the decision.

Administrative review of any hearings officer's decision provided in the fair hearings rules must be initiated by the appellant (applicant/member). Program staff may disagree with the decision; however, the hearings officer's decision is final. Disagreements on policy or legal issues may be submitted by program staff to the regional attorney.

7700 Fair Hearings for Managed Care Organization Determinations

If an applicant wishes to request a fair hearing with the state of Texas regarding a Medically Dependent Children Program (MDCP) waiver eligibility denial, he or she must contact the Program Support Unit (PSU) as instructed in the denial notification.

In addition to appealing an adverse action not related to eligibility, the MDCP waiver member may also request a state fair hearing by contacting PSU.

8000 Utilization Management and Review by the State

Utilization Review (UR) is a division within the Medicaid/CHIP Division of the Health and Human Services Commission (HHSC). UR was created by Senate Bill 348, 83rd Legislature Regular Session, 2013. This bill amended Section 533.00281 of Texas Government Code to allow HHSC to review utilization of the STAR+PLUS Home and Community Based Services (HCBS) Program. HHSC has extended the scope of UR to include review of appropriate utilization of STAR Kids Medically Dependent Children Program (MDCP) services as well as state plan services provided in STAR Kids.

STAR Kids managed care organizations must make documents, assessments, notes, and authorizations contained in a STAR Kids member's file available upon request from UR. STAR Kids MCOs must participate and make appropriate staff available for utilization reviews conducted by UR upon request from that division.

8100

Reserved

APPENDIX I STAR KIDS ISP NARRATIVE FORM

Health and Human Services Commission

STAR Kids
Individual Service Plan (ISP) - Narrative Form

Form 2604
11/1/2016

I. Member and Service Coordinator Information

1. Applicant/Member Name	2. Date of Birth	3. Medicaid Number	4. Social Security Number
5. Service Coordinator Name		6. Service Coordinator Phone Number	7. Service Coordination Level
8. MDCP ISP start date	9. MDCP ISP end date	10. ISP revision date	

II. Medical Information

Diagnoses and Conditions

Medications

Hospitalizations in the last 12 months

Date	Reason	Plan to Prevent Readmission

Specialists

Provider Name	Provider Type	Frequency of Provider Visits	Provider Contact Information

Medical Referrals

Provider Name	Provider Type	Purpose	Expiration

III. Applicant's/Member's Preferences, Strengths, and Unique Considerations

1. Strengths	2. Hobbies and Interests	3. Community-based activities

4. Goals

a. Developmental Goals
Short-Term:
Long-Term:

b. Educational Goals
Short-Term:
Long-Term:

c. Medical Goals
Short-Term:
Long-Term:

d. Social Goals
Short-Term:
Long-Term:

e. Service Coordination Goals
Short-Term:
Long-Term:

f. Other Goals
Short-Term:
Long-Term:

IV. Applicant's/Member's Preferences, Strengths, and Unique Considerations (continued)

5. Who does the applicant/member/Legally Authorized Representative (LAR) want to directly involve in support planning? (this can be anyone, including provider staff)		
Name	Relationship	Preferred method of participation e.g. in-person, by telephone, frequency, location, etc.
Physical Address	Phone	Email
Mailing Address		
Name	Relationship	Preferred method of participation e.g. in-person, by telephone, frequency, location, etc.
Physical Address	Phone	Email
Mailing Address		
Name	Relationship	Preferred method of participation e.g. in-person, by telephone, frequency, location, etc.
Physical Address	Phone	Email
Mailing Address		
6. Permanency/Transition Planning		
7. Service Preferences		
8. Things that are working well		
9. Things that could be working better/barriers		
10. Family considerations		

11. Current DME and Supplies		
Product Type	Replacement Frequency	Concerns/Notes

V. Service Planning Considerations

1. Medicaid State Plan Services (include only capitated services)

	(a) Service/Item Type and (b) Provider	(c) Rationale	(d) Hours per week	(e) Begin/End Date
☐	Personal Care Services (PCS)			
		☐ CDS Option ☐ SRO Option		
☐	Community First Choice - Attendant care			
		☐ CDS Option ☐ SRO Option		
☐	Community First Choice - Habilitation			
		☐ CDS Option ☐ SRO Option		
☐	Community First Choice - Emergency response services (ERS)		N/A	N/A
☐	Community First Choice - Support Management		N/A	N/A
☐	Financial Management Services (CDS only)		N/A	N/A
		☐ CDS Option ☐ SRO Option		
☐	Private duty nursing (PDN) (RN)			
☐	Private duty nursing (PDN) (LVN)			
☐	Home health skilled nursing (RN)			
☐	Home health skilled nursing (LVN)			
☐	Home health aide services			
☐	Prescribed pediatric extended care (PPECC) services			
☐	Physical Therapy (PT)		N/A	N/A

V. Service Planning Considerations (continued)

☐	Occupational Therapy (OT)		N/A	N/A
☐	Speech Therapy (ST)		N/A	N/A
☐	Mental health rehabilitation		N/A	N/A
☐	Mental health targeted case management		N/A	N/A
☐	Medical supplies		N/A	N/A
☐	Durable medical equipment (DME)		N/A	N/A
☐	Other:			
☐	Other:			

Additional Service Details

2. Medically Dependent Children's Program (MDCP) services (if applicable)

	(a) Service/Item Type and (b) Provider	(c) Rationale	(d) Hours per week	(e) Begin/End Date
☐	In-home respite (RN)			
		☐ CDS Option ☐ SRO Option		
☐	In-home respite (LVN)			
		☐ CDS Option ☐ SRO Option		
☐	In-home respite (attendant)			
		☐ CDS Option ☐ SRO Option		
☐	Out-of-home respite			
☐	Flexible Family Support Services (RN)			
		☐ CDS Option ☐ SRO Option		
☐	Flexible Family Support Services (LVN)			
		☐ CDS Option ☐ SRO Option		

V. Service Planning Considerations (continued)

☐	Flexible Family Support Services (attendant)			
		☐ CDS Option ☐ SRO Option		
☐	Employment Assistance			
		☐ CDS Option ☐ SRO Option		
☐	Supported Employment			
		☐ CDS Option ☐ SRO Option		
☐	Financial Management Services (CDS Only)		N/A	N/A
		☐ CDS Option ☐ SRO Option		
☐	Adaptive Aids		N/A	N/A
☐	Minor Home Modifications		N/A	N.A
☐	Transition Assistance Services		N/A	N/A

Additional Service Details

3. Health Home (Service Coordinator should explain health homes to the member and family before responding):

☐ Currently receives services through a health home
- If yes, to what extent are services received/coordinated through health home?

☐ Does not currently receive services through a health home, but could benefit from access
☐ Does not currently receive services through a health home, but has requested access
☐ Not interested in a health home

4. Value-added Services

Service Type	Begin/End Date

Additional Service Details

5. Non-capitated Medicaid services (including waiver programs)

Waiver or program name	Service Type	Hours per week	Begin/End Date

V. Service Planning Considerations (continued)

6. Educational Services (SHARS)

Name	Service Type	Hours per week	Begin/End Date

7. Non-Medicaid State Program Services

Name of Program	Service Type	Hours per Week	Begin/End Date

8. Informal/Community Supports (include Family, Community Organizations)

Name	Relationship	Service Type	Hours per week	Begin/End Date

9. Is the applicant/member/LAR interested in additional resources to become more involved in the community?

- ☐ Yes, resources provided during home visit.
- ☐ Yes, resources will be sent to applicant/member/LAR.
- ☐ No, applicant/member/LAR is not interested in additional community resources.

Service Type Detail

10. Medicare and Other Payers (include Medicare, VA, TRICARE, private insurance, and other payers)

Name of Resource	Policy number	Service Type	Hours per Week	Begin/End Date

Service Type Detail

VI. Authorizations Requested/Needed

Item/Service	Provider	From:	To:

VII. Complaints and Appeals Log

Type	Submission Method	Date	Actions	Resolution

VIII. Completed Assessments

Screening/Assessment Name/Type	Assessor Name	Date

IX. Follow-Up Items or Assessment Needs

Item/Screening/Assessment	Responsible Party

X. Service Coordinator Follow-up Schedule

Next Scheduled Contact	Method of contact			
	☐ By Telephone	☐ By Email	☐ In Person	☐ By Mail
Annual Reassessment Due				
Additional Comments				

XI. Signature/Approval

Applicant/Member/LAR Rights
STAR Kids offers a number of services and provider types from which families may choose. Your signature on this plan is required to document your participation in the development of this ISP. However, your signature on this form in no way affects your right to request a fair hearing if you disagree with this ISP. You have the right to make a change in the plan of care before the end of the plan year. You can choose to authorize your service coordinator to make such changes on your verbal instruction or you may choose to have any changes you request signed before they are made final. Your choice in no way affects your right to request a fair hearing. You will receive copies of any plan changes made during the ISP period.

Applicant/Member/LAR Attestation
I understand that this plan of care has been developed with consideration to the applicant's/member's health and safety and my signature is required for services to be authorized. I understand that my signature does not affect my right to a fair hearing if I disagree with this plan. I understand that I will be provided with a copy of this ISP and any revisions to it. I also understand that I may make changes in the plan before the end of the ISP period by contacting my service coordinator. Choose one: ☐ I want to be allowed to authorize changes to the Individual Service Plan verbally to the service coordinator. ☐ I want my MCO to require my signature to make changes to the Individual Service Plan.

Printed Name - Member/LAR	Signature - Member/LAR	Date

Service Coordinator
This plan was developed in collaboration with the applicant/member and/or LAR(s). I have reviewed the rights and responsibilities with the applicant/member/LAR(s). I also have informed them that they have the right to make changes in the ISP before the end of the period and may do so by contacting me.

Printed Name - Service Coordinator	Signature - Service Coordinator Name	Date

APPENDIX I STAR KIDS ISP - NARRATIVE FORM - INSTRUCTION

Instructions

PURPOSE

The **STAR Kids Individual Service Plan (ISP) – Narrative Form** (henceforth, ISP) is required to be completed for a member or applicant's initial assessment and for all annual and revision assessments.

The STAR Kids ISP:

- is developed through a person-centered planning process;
- occurs with the support of a group of people chosen by the member (and the legally authorized representative (LAR) on the individual's behalf); and,
- accommodates the member's style of interaction, communication and preferences regarding time and setting.

The STAR Kids ISP is used to:

- document findings from the STAR Kids Screening and Assessment Instrument (SAI);
- to develop a service plan for services received through the STAR Kids MCO;
    - for STAR Kids MDCP members, the ISP is also used to develop an MDCP service plan that falls within the member's allowable cost limit;
- document services received through third party sources, such as 1915(c) waivers operated by DADS and DSHS;
- identify applicant or member's strengths, preferences, and unique considerations;
- identify what is important to the applicant or member;
- identify natural supports available and needed service system supports;
- document preferences for when and how to receive services;
- identify any special needs, requests, or considerations for the applicant or member; and
- document and address the applicant or member's unmet needs.

PROCEDURE

When to Prepare or Update

The STAR Kids ISP must be completed in its entirety following the member's or applicant's assessment with the STAR Kids SAI. The form is updated annually and for changes related to the member's medical condition and/or functional ability. If a member, applicant, or LAR does not know the information requested or refuses to answer, document that on the ISP.

Form Retention

Keep the original copy of the form in the member's case record. The MCO must provide a printed or electronic copy of the ISP to each Member or the Member's LAR following any significant update and no less than annually. The MCO must provide a copy of the ISP to the Member's providers and other individuals specified by the Member or Member's LAR. The MCO

must give the completed ISP in the format that the Member or Member's LAR requests. The MCO must write the ISP in plain language that is clear to the Member or the Member's LAR and must be furnished in Spanish or languages of other Major Population Groups if requested.

DETAILED INSTRUCTIONS

How to Complete the STAR Kids Individual Service Plan – Narrative Form

The STAR Kids ISP – Narrative Form is designed to complement the STAR Kids SAI. Where appropriate, these instructions note the information which may be copied from appropriate fields on the SAI.

The information contained in this form is obtained through an information gathering conversation (the discovery process) with the applicant or member about their abilities, preferences, and goals in line with person centered planning principles. The service coordinator should make his best effort to communicate with the member. If the member is unable to participate in the discovery process due to age or disability, the service coordinator can supplement with information from the LAR.

Section 1. Member and Service Coordinator Information

1. Applicant/Member Name - Fill in the applicant or member's name, as found on Section A, Item 1 of the SAI.

2. Date of Birth – Fill in the applicant or member's date of birth, as found on Section A, Item 3 of the SAI.

3. Medicaid Number – Fill in the applicant or member's Medicaid number, as found on Section A, Item 10c of the SAI. If the individual does not yet have a Medicaid number, do not fill out this item.

4. Social Security Number – Only complete this item if the applicant does not yet have a Medicaid number (i.e., an applicant for MDCP). Fill in the applicant or member's Social Security Number, as found on Section A, Item 10a of the SAI.

5. Service Coordinator Name – Enter the individuals' named service coordinator's name. If the individual does not have a named service coordinator, enter the name of the service coordinator assisting with this service planning process.

6. Service Coordinator Phone Number – Enter the member's named service coordinator's phone number. If the applicant or member does not have a named service coordinator, enter the phone number of the service coordinator assisting with this service planning process.

7. Service Coordination Level – Enter the member's current service coordination level: Level 1, Level 2, or Level 3.

8. MDCP ISP Start Date –This question is only applicable for members receiving MDCP services. Enter the effective date of the MDCP ISP. This should match the date submitted on the electronic ISP. Otherwise, enter "N/A."

9. MDCP ISP End Date – This question is only applicable for members receiving MDCP services. Enter the end date of the MDCP ISP. This should match the date submitted on the electronic ISP. Otherwise, enter "N/A."

10. ISP Revision Date – This question is only applicable for members receiving MDCP services. Enter the date that the MDCP ISP was last revised, if applicable. Otherwise, enter "N/A."

Section 2. Medical Information

1. Diagnoses and Conditions – Consider information in Section D, Item 1 of the SAI.

2. Medication – Consider including information from Section H, Item 1 of the SAI.

3. Hospitalizations in the last 12 months – Consider including information from Section D, Items 10-12 of the SAI.

4. Specialists – Enter the names, provider types, frequency of visits, and contact information for the individual's specialist provider. Include all current specialists that are significant to the individual's care.

5. Medical Referrals – Consider including information from Section Z of the SAI.

Section 3. Applicant's/Member's Preference, Strengths, and Unique Considerations

1. Strengths – Consider information from Section E, Item 7 of the SAI.

2. Hobbies and Interests – Ask the member, applicant, or LAR about their hobbies and interests - what they like to do in their free time.

3. Community-based activities – Ask the member, applicant, or LAR about the community activities they participate in.

4. Goals – Ask the member, applicant, or their LAR about their developmental, educational, medical, social, service coordination, and other goals. Consider including both short and long-term goals. Consider information from Section C, Items 1-2 and Section P, Item 1 (if applicable).

5. Who does the applicant/member/Legally Authorized Representative (LAR) want to directly involve in support planning? – Note the name, relationship to the member/applicant/LAR, contact information, and preferred method of participation for people who are participating in the service planning process.

6. Permanency/Transition Planning – Permanency planning is for an applicant or member who is transitioning from a foster care home environment to out-of-home care.

7. Service Preferences – Ask about how the applicant or member likes to receive services. This could include a discussion of consumer-directed services, and could also include preferences about learning style when learning how to do new things.

8. Things that are working well – Ask about the services and supports that are helpful, that work well, that help the applicant or member stay healthy and remain safe in the community.

9. Things that could be working better/barriers – Ask about barriers to receiving the care that is needed and other issues the applicant, member or LAR might be facing.

10. Family Considerations – Consider information from Section E of the SAI.

11. Current DME and supplies – Consider information from Section D, Items 13-15 of the SAI.

Section 5. Service Planning Considerations

1. State Plan services – List Medicaid State Plan services the member is receiving or approved to receive, including service type, provider, hours per week (if applicable), begin/end date, and whether the member has chosen the Consumer Directed Services (CDS) or Service Responsibility Option (SRO) (if applicable). Also include a brief rationale (i.e., functional deficit, skilled nursing need, promote mental health well-being). Consider information from Section H, Item 6 of the SAI.

If the applicant or member is receiving services through the Early Childhood Intervention (ECI) program, be sure to note those here. The service coordinator should attach the Individual Family Service Plan (IFSP) that is used in the ECI program to this ISP document, if available.

2. Medically Dependent Children Program (MDCP) services – List MDCP services the applicant member is receiving or approved to receive, including service type, provider, hours per week and whether the member has chosen the Consumer Directed Services (CDS) or Service Responsibility Option (SRO). Also include a brief rationale (i.e., respite, functional/medical deficit, promote independence, enable move to a community based setting). This list should match the services submitted with the electronic ISP. This item is only applicable to MDCP members and applicants. If the member or applicant is not in MDCP, this item should be left blank.

3. Health home - Document member's utilization of or interest in a health home.

4. Value-added Services – List value-added services that the member is receiving or is approved to receive, including service type, begin/end date, and additional details.

5. Non-capitated Medicaid services - List non-capitated services that the applicant or member is receiving, including the waiver or program, service type, hours per week (if applicable), and begin/end date. Refer to STAR Kids Managed Care Contract Section 8.1.24.8 for a list of Medicaid non-capitated services. This category includes services received through DADS and DSHS waiver programs.

Examples include:

- Community Living and Support Services (CLASS);

- Deaf Blind with Multiple Disabilities (DBMD);
- Home and Community-Based Services (HCS);
- Texas Home Living (TxHmL); and
- Youth Empowerment Services (YES).

Do not include Medicaid services provided through SHARS, which are captured in the next item. Consider information from Section C, Item 6 of the SAI.

If the applicant or member is receiving Early Childhood Intervention (ECI) services, be sure to note if they are receiving ECI targeted case management or specialized skills training, which are non-capitated ECI services. It is also recommended the service coordinator attach the Individual Family Service Plan (IFSP) used in the ECI program to the ISP document, if available**.**

6. Education services – List services applicant or member is receiving through their school, including service type, hours per week (if applicable), begin/end date. Include services received in both the school and home setting. Also include Medicaid services provided through the SHARS program. Consider information from Section B of the SAI.

Remember that if the applicant or member has an individual education plan (IEP) through the school, the IEP is considered confidential and may only be shared with the MCO with permission from the member, applicant, or LAR. If the family does choose to share the IEP, it might be helpful to attach it to the ISP document.

7. Informal/Community supports – List other informal or community supports the applicant or member receives, including the name of the services, the relationship of the provider to the member, the service type, the hours per week, and the begin/end date. This does not need to be an exhaustive list, but should include those informal supports that are most important to the member. Consider information from Section E of the SAI.

8. Non-Medicaid State Program Services -- List services that the member is receiving through state programs other than Medicaid, including the program name, service type, hours per week (if applicable), and begin/end date. Examples might include Women, Infants, and Children (WIC); Supplemental Nutrition Assistance Program (SNAP); or the Department of Assistive and Rehabilitative Services (DARS) autism program.

9. Is the applicant/member/LAR interested in additional resources to become more involved in the community?- The purpose of this question is to generate potential referrals to community organizations. Examples could include volunteer opportunities at a local food bank or participation in a support or advocacy group.

10. Services received through Medicare and other payers – If the member has Medicare or another third party resource that pays for services, list the name of the resource, policy number, service type, hours per week, begin/end date, and other details about the service. Examples include Medicare, TRICARE, and other third party payers.

Section 6. Authorizations Requested/Needed

Use this section to record the services for which the member is requesting or needs authorization based on results from the SK-SAI. Include the service or item, provider, and begin/end dates.

Section 7. Complaints and Appeals Log

Use this section to record the member's complaints and appeals. Record the type of complaint/appeal, the method of submission, the date, the actions taken, and the ultimate resolution.

Section 8. Completed Assessments

Use this section to record any assessments that the member has completed. Record the type or name of the assessment, the assessor name (if known), and the date. Examples could include a speech therapy evaluation or the CANS.

Section 9. Follow-up Items or Assessment Needs

Use this section to record any additional follow-up screenings or assessments that are needed. Include the assessment name and the entity or person responsible for completing it. Examples could include a speech therapy evaluation or the CANS.

Section 10. Service Coordinator Follow-up Schedule

Use this section to document the service coordinator follow-up schedule. Members must receive in-person and telephonic contacts according to their service coordination level, as described in STAR Kids Managed Care Contract Section 8.1.38.6. Record the date of the next scheduled contact, the method of contact, the next reassessment date, and any other comments.

Section 11. Signature/Approval

TALK TO THE MEMBER, APPLICANT, OR LAR ABOUT THEIR RIGHTS AND RESPONSIBILITIES, AS DESCRIBED IN THIS SECTION. TALK TO THE MEMBER ABOUT WHETHER THEY WANT TO ALLOW CHANGES TO THE ISP WITHOUT A SIGNATURE (I.E., OVER THE PHONE), OR IF THEY WANT TO SIGN OFF ON ALL ISP CHANGES. CHECK THE APPROPRIATE BOX. THE APPLICANT, MEMBER OR LAR THEN SIGNS AND DATES THIS SECTION TO AGREE TO THE ATTESTATION. THE SERVICE COORDINATOR SIGNS AND DATES THE FORM TO INDICATE THEY DEVELOPED THE ISP BASED ON NEEDS AND IN COLLABORATION WITH THE MEMBER, APPLICANT, OR LAR AND THAT THEY REVIEWED THE RIGHTS AND RESPONSIBILITIES.

MCO BUSINESS RULES FOR SK-SAI & SK-ISP

Table of Contents

1 SK-SAI and SK-ISP Business Rules

This purpose of this document is to communicate rules that the STAR Kids MCOs should follow when processing the STAR Kids Assessment Instrument (SK-SAI) and STAR Kids Individual Service Plan (SK-ISP), including interfacing with the TMHP LTC Online Portal system.

1.1 General Rules for the SK-SAI

1.1.1 SK-SAI Design & Layout

The MCO must:

1. Adhere to the HHSC Document Map for the flow of Modules, Sections within Modules and Fields within Sections (aka skip logic and triggers).
2. Adhere to the HHSC Document Map for the field data types, values, limits and required vs conditional or optional rules.
3. Adhere to the XML schema for the SK-SAI interface file when submitting to TMHP.

1.1.2 SK-SAI Processing

The MCO must:

1. Prevent duplicate SK-SAIs from being submitted for the same individual.
2. Allow for submission of an Abbreviated form (see Section 8.1.39.1). The abbreviated form is not a subset of the SK-SAI. The abbreviated form is a convenience for the user to create an SK-SAI from a previously submitted form, thereby accepting previously entered values in fields and changed values in others.
3. Enforce SK-SAI timeframes as outlined in Sections: 8.1.38.16.5, 8.1.39, 8.3.1 of the MCO contract.
4. Prevent submission of an SK-SAI Reassessment if an Initial Assessment is not on file for the individual.
5. Prevent submission of an SK-SAI Significant Change in Status Reassessment (SCSR), for MDCP or CFC, if an SK-SAI or MNLOC with MN Approval within 365 days is not on file at the MCO.
6. Prevent submission of any SK-SAI requesting MN determination for CFC, if CFC services have not been requested (i.e., if PCAM Section P is not requested for assessment by the member).
7. Prevent submission of any SK-SAI requesting MN determination for MDCP, if the client is not an existing MDCP client or if a referral number has not been received from HHSC Program Support Unit (PSU).
8. Prevent submission of an SK-SAI Initial Assessment for an MDCP child without Medicaid (i.e., Medical Assistance Only [MAO]), if a referral number has not been received from HHSC PSU.
9. Prevent completion of the PCAM (even if triggered), including Section P, when a STAR Kids member is receiving CFC services from their enrollment in an IDD waiver (CLASS, DBMD, HCS, TxHmL).
10. Ensure the license associated with the Medical Provider, whose NPI/API is listed in SK-SAI field A24f, is valid prior to submission to TMHP.
11. Follow rules for the submission of any SK-SAI correction or inactivation, as laid out in the respective scenario sections below.
12. Prevent submission of any SK-SAI requesting MN determination more than 90 calendar days before individual's SK-ISP expires.
13. Ensure SK-SAIs submitted by the same MCO meet the following conditions:
    a. MCO <u>may</u> submit an inactivation at any time and for any reason described in Inactivation Scenarios below.

b. MCO may only submit a major correction on an SAI that is in the MN workflow that has not reached final disposition.
c. MCO may only submit a major or minor correction on an SAI within 14 days of the initial submission.

14. Ensure Transfer SK-SAIs are managed in the following manner by the Gaining (see Transfer Scenarios section for details):
    a. Gaining MCO may only submit an inactivation for an SK-SAI submitted by the original MCO prior to the assessment reaching final disposition in the TMHP Portal.
    b. Gaining MCO may not submit inactivation on any SAI pending fair hearing.
    c. Gaining MCO may not submit a major or minor correction on an SAI completed by a previous MCO.
15. Allow for submission of an SK-SAI for a child referred by HHSC PSU (from the interest list) where the Social Security Number (SSN) is not available and the Medicaid ID is not available. See the document map for allowable value in these fields under this condition.
16. Redact any suffix (e.g., Jr. or III) from the "Name" field (A1) prior to submission.

1.2 General Rules for SK-ISP

1.2.1 SK-ISP Design & Layout

The MCO must:

1. Adhere to the ISP PDF provided by HHSC for the design and layout of the Service Tracking form in the MCO system. This form corresponds to the SK-ISP 278 data.
2. Transmit the SK-ISP Service Tracking data (not the narrative addendum) to TMHP via an X12 278 EDI transaction:
    a. Field data types, values, limits and identification of required vs optional must match the X12 278 Companion Guide.
3. Upon request by HHSC the MCO must post to TxMedCentral in a PDF format the ISP Narrative addendum and the ISP Summary Tracking form for the individual(s) identified by HHSC.
    a. Refer to the STAR Kids Handbook for the file format and TxMedCentral location.
4. Ensure the naming convention established by TMHP is adhered to for the associated transmission of the SK-SAI Substantive Response file. ISP:
    a. *ISP.*.txt, or*
    b. *ISP.*.dat or*
    c. *ISP.*.Zip*
    d. *Note: the * can be replaced with any name and no spaces within the filename*

1.2.2 SK-ISP Processing

1. For all individuals the MCO must:
    a. Enforce the SK-ISP requirements as outlined in Sections: 8.1.38.3 and 8.3.4 of the MCO contract.
    b. Ensure the individual's Medicaid Number on the SK-ISP matches the Medicaid Number on the associated SK-SAI.
2. For existing MDCP members the MCO must:
    a. Submit the Reassessment SK-ISP Summary Tracking form (as a 278 transaction) to TMHP within 30 days of the annual ISP expiration date for all Members receiving MDCP services.

b. Establish the begin date of the Reassessment ISP as the first day of a month and must be one (1) day following the expiration of the prior ISP.
c. Set the ISP cost ceiling, for an MDCP child, based on the RUG received from TMHP in the SK-SAI Substantive Response File.
d. Set the Lifetime Limits on associated services for an MDCP child in accordance with service limits described in the STAR Kids Handbook.
e. Ensure the individual's Medicaid Number on the SK-ISP matches the Medicaid Number on the SK-SAI prior to submission of the SK-ISP X12 278 transaction to TMHP.
f. Submit the SK-ISP 278 Transaction to TMHP (see Appendix D for details on the location and response file handling for this transaction).

3. For applicants of MDCP that are received as a referral from HHSC PSU the MCO must:
    a. Set the ISP cost ceiling, for an MDCP child, based on the RUG received from TMHP in the associated SK-SAI Substantive Response File.
        1. This is a link to the Resource Utilization Groups (RUG) Individual Plan of Care (IPC) Cost Limits, Provider Types and Service Rates: http://www.dads.state.tx.us/handbooks/appendix/15.htm
    b. Set the Lifetime Limits on associated services for an MDCP child in accordance with service limits described in the STAR Kids Handbook.
    c. The following process is required to establish the begin and end date of the ISP:
        1. MCO must post the ISP Summary Tracking Form on TxMedCentral for the PSU to perform their process.
            i. Once PSU processes the ISP, PSU will issue a Notification of Enrollment form to individual/member and post a copy of the Notification of Enrollment form to TxMedCentral for the MCO.
            ii. The Notification of Enrollment form will have the effective date for MDCP services and the MCO cannot initiate MDCP services until the Notification of Enrollment form is received.
        2. Once the MCO receives confirmation of the Begin and End dates for the ISP the MCO must:
            i. Update the ISP dates in their system and submit the ISP Summary Tracking 278 transaction to TMHP per normal processing rules.
            ii. Submit the SK-ISP within 60 days from the date of referral for MDCP services.

2 Rules for SK-SAI Interfaces with TMHP

2.1 TMHP Document Locator Number (DLN)

A Document Locator Number (DLN) is a unique identifier assigned by TMHP upon successful submission of an SK-SAI by the MCO. Although a DLN is assigned, this is no guarantee the SK-SAI will be successfully processed within the workflows on the TMHP LTC Online Portal. An SK-SAI DLN could result in an 'Invalid/Complete' status if the rules are not followed for the fields in Section R for RUG determination as defined in the Document Map. The DLN can be used on the TMHP LTC Online Portal to locate SK-SAIs, successfully submitted by the MCO, using their security access to that system. The assigned DLN must be maintained in the MCO system to allow for further systems processing operations (correction and inactivation) with TMHP.

2.2 Transmitting SK-SAIs to TMHP:

An SK-SAI must be transmitted to the TMHP LTC Online Portal using the XML schema for the interface file:

1. The schema is the layout for the SK-SAI fields as defined in the Document Map.
2. The filename for the SK-SAI batch file is: <SKSAIPCYYYYMMDDSEQ> where
    a. SKSAI = STAR Kids Screening and Assessment Information
    b. PC = MCO Plan Code
    c. YYYYMMDD = Date file submitted
    d. SEQ = 3 digit number to denote batch sequence of the file.
3. The details of the fields within this response file can be found in the SK-SAI_Inbound Batch.
4. A batch file produced by the MCO with SK-SAI forms, in the XLM schema format, must be placed on TxMedCentral in the designated folder assigned to the MCO: \\...\<MCO>GENL\... where <MCO> corresponds to the abbreviated MCO name.
    a. AETGENL - AETNA
    b. AMCGENL – AMERIGROUP Texas, Inc.
    c. BCBGENL – Blue cross Blue Shield
    d. CFGENL - Community First Health Plans
    e. CKCGENL - Cook Children's Health Plan
    f. CMCGENL - Children's Medical Center
    g. DRCGENL - Driscoll Children's Health Plan
    h. SUPGENL – Superior Health plan
    i. TXCGENL - Texas Children's Health Plan
    j. UHCGENL – United Healthcare - Texas
5. The MCO may submit up to 100 files per batch file and 20 batch files in a single day for a total of 2,000 forms per day.

2.3 SK-SAI Response Files from TMHP

There are two types of response files (Validation Response and Substantive Response) transmitted by TMHP to the MCOs, depending on the type of SK-SAI assessment submitted and form action indicated by the MCO.

The MCO will receive a Validation Response from TMHP for all transmitted SK-SAI forms indicating the receipt of the SK-SAI as either accepted or rejected.

TMHP will only send the more substantive response file when the status of the Medical Necessity Determination, the validation of the Medicaid Number and/or the calculated Resource Utilization Group (RUG) is required (i.e. an individual requesting MDCP or CFC services).

Two fields in Section Z of the SK-SAI CORE module are used by the MCO to inform TMHP the steps to be taken in their system and operational workflow processes for Medical Necessity (MN) Determination and Calculation of RUG. These fields must be completed by the MCO to inform TMHP of actions to be taken:

1. Z5a ‘MN Determination Needed?’ must always be completed by the MCO to inform TMHP if the determination of Medical Necessity (MN) is needed on the individual for MDCP or CFC program eligibility.
2. Z5b ‘MDCP RUG Calculation Required?’ must always be completed by the MCO to inform TMHP when a RUG is needed for an individual requesting MDCP services. The RUG is only relevant to the MDCP services.

There is also a field within the inbound SK-SAI XML schema, not a field on the form, which is used by TMHP to determine the steps to be taken in their system to inactivate a form:

1. The 'Form Action' field is completed by the MCO to inform TMHP to inactivate a previously submitted SK-SAI. This action is further described in the Inactivation scenario within this document.

2.3.1 Validation Response file

1. The Validation Response file will be placed on TxMedCentral in the corresponding MCO folder: \\...\<MCO>GENL\... where <MCO> corresponds to the abbreviated MCO name:
    a. AETGENL - AETNA
    b. AMCGENL – AMERIGROUP Texas, Inc.
    c. BCBGENL – Blue Cross Blue Shield
    d. CFGENL - Community First Health Plans
    e. CKCGENL - Cook Children's Health Plan
    f. CMCGENL - Children's Medical Center
    g. DRCGENL - Driscoll Children's Health Plan
    h. SUPGENL – Superior Health plan
    i. TXCGENL - Texas Children's Health Plan
    j. UHCGENL – United Healthcare - Texas
2. The naming convention for the validation response file is <fileid>.RSP<SKSAIPCYYYYMMDDSEQ> where:
    a. <fileid> = an eight (8) digit TMHP-assigned identifier followed by a period (.) and prepended to the filename.
    b. RSP = Response file
    c. <SKSAIPCYYYYMMDDSEQ> = Inbound SK-SAI File name
3. Each transmitted SK-SAI by the MCO to TMHP will be evaluated for acceptance or rejection using two levels of validation: schema validation and business validation.
4. The details of the fields within this response file can be found in the SK_SAI_Batch_Validation_Response schema file and Appendix B of this document.
5. The information communicated by TMHP to the MCO in this response file should be used by the MCO to determine next steps in their system and operations processes.
6. The DLN received in the Inbound SK-SAI becomes the Parent DLN in the Validation Response file when the MCO has requested a Major or Minor correction and the SK-SAI has successfully passed business validation; otherwise it will be blank.
7. The DLN received in the Inbound SK-SAI becomes the Inactivated DLN in the Validation Response file when the MCO has requested an inactivation of the SK-SAI by indicating a 'Form Action = Inactivate' and the SK-SAI has successfully passed business validation; otherwise it will be blank.
8. The DLN received in the Inbound SK-SAI becomes the Submitted DLN (document locator number previously created and received from TMHP for an SK-SAI) in the Validation Response file only when the MCO has requested an Inactivation or a Major / Minor correction on the SK-SAI and the validations failed, otherwise it will be blank.
9. Validation status will indicate the results of both the schema and business validation and can be Accepted or Rejected.

10. Reject reason field will list up to 100 errors (per form) that were found during both types of validation, schema and business.

2.3.1.1 SK-SAI Schema Validation

The schema validation checks to see if the SK-SAI conforms to the XML schema, which is based on the Document Map. It is the State's expectation that the MCO will validate the data prior to submission and the SK-SAI will be rejected if it does not pass this level of validation.

1. For Inactivation:
    a. There are no schema validations. The business validations confirm the values submitted.
2. For other scenarios:
    a. The Schema validation is part of the standard XSD file sent to the MCO's with all length and format validations being done on SK-SAI fields. The required/optional field validation is done on the CORE Module only.

2.3.1.2 SK-SAI Business Validation

The business validation checks to see if the SK-SAI conforms to the business rules associated with creation of the DLN in the TMHP LTC Online Portal. The business validations executed by TMHP (per SK-SAI) can be found in Appendix A of this document.

2.3.2 Substantive response file

1. The Substantive Response file will be placed on TxMedCentral in the corresponding MCO folder: \\...\<MCO>GENL\.where <MCO> corresponds to the abbreviated MCO name.
    a. SUPGENL – Superior Health plan
    b. UHCGENL – United Healthcare - Texas
    c. AMCGENL – AMERIGROUP Texas, Inc.
    d. CFGENL - Community First Health Plans
    e. TXCGENL - Texas Children's Health Plan
    f. CKCGENL - Cook Children's Health Plan
    g. DRCGENL - Driscoll Children's Health Plan
    h. AETGENL - AETNA
    i. BCBGENL – Blue cross Blue Shield
    j. CMCGENL - Children's Medical Center
2. The naming convention for the validation response file is: SUB<SKSAIPCYYYYMMDD> where:
    a. SUB = Substantive Response file
    b. <SKSAIPCYYYYMMDDSEQ> = Inbound SK-SAI File name
3. The details of the fields within this response file can be found in the SK-SAI_Batch_Substantive_Response schema and Appendix C of this document.
4. The information that is communicated from TMHP to the MCO in this response file must be used by the MCO to determine next steps in their system and operations processes. The information includes:
    a. Medicaid Number when obtained by TMHP for the individual who was pending Medicaid (indicated by the MCO as a plus sign (+) in the A10c field). Note: the process of obtaining a Medicaid Number by TMHP (from TIERS) could take up to

180 days. The SK-SAI remains in a 'Medicaid ID Pending' status on the TMHP LTC Online Portal during this time period.

b. RUG value when the MCO indicated a one (1) for yes in Z5b field.
c. Notes from TMHP operations staff when additional information is needed from the MCO to determine Medical Necessity.
d. Medical Necessity status as it progresses at TMHP to a final outcome.
e. Medicaid Number validation status resulting from checking for a valid Medicaid Number in the State systems. It is expected that the MCO will have validated the Medicaid Number against their local data prior to submitting an SK-SAI to prevent unnecessary errors.

2.4 SK-SAI Rules for MN, RUG and Medicaid Number

The MN Status and Medicaid Number Validation Status fields in the SK-SAI substantive response file work together to communicate the status of the corresponding processes at TMHP. As the SK-SAI moves through the Medical Necessity Determination and the Medicaid Number Validation workflows at TMHP there are statuses that trigger the system to send the SK-SAI substantive response to report status or in some cases request action required by the MCO.

The SK-SAI field A10c Medicaid Number is used by TMHP to determine next steps in their process. The A10c field can be completed with either a valid Medicaid Number or a plus sign '+'.

The Medicaid Number should be completed as a plus sign '+' when the following conditions are met:

1. the individual has been released from the MDCP Interest List and
2. the MCO has received a referral number from the State PSU staff and
3. the individual does not yet have Medicaid eligibility.

Otherwise, the field should contain a Medicaid Number, which was validated by the MCO using their system data to reduce rejections in the Medicaid Number validation process.

When a plus sign '+' in the A10c field is received at TMHP the Medical Necessity (MN) process is executed first, followed by the Medicaid Number validation process. When a valid Medicaid Number is received at TMHP in the A10c field, the Medicaid Number validation process is executed first followed by the MN process.

Therefore, a combination of statuses could be returned in the Medicaid Number Validation Status field and MN Status fields of the SK-SAI substantive response as outlined in the tables below.

Table 1. SK-SAI for Individual released from MDCP Interest List (no Medicaid Number)

A10c Plus Sign '+' submitted - Medical Necessity (MN) starts first - Medicaid Number Validation starts second	
MN Status	**Medicaid # Validation**
In progress	Not started
Info Needed	Not started
Denied	Not started
Approved	Invalid
Approved	Valid
Approved	In Progress

Table 2. SK-SAI for Individual with Medicaid Number

A10c = Medicaid Number - Medicaid Number Validation starts first - Medical Necessity (MN) starts second	
MN Status	**Medicaid # Validation**
In progress	Valid
In progress	In Progress
Info Needed	Valid
Denied	Valid
Not started	Invalid
Approved	Valid

2.5 MN Status from TMHP

The Substantive Response file will be used to communicate the status of MN determination when required at TMHP. The MCO must wait for a final determination of MN from TMHP before establishing the ISP for an MDCP or CFC individual.

1. **MN status = 'Approved'** means the MCO must move on to creation of the ISP and use the RUG received for an MDCP individual.
2. **MN status = 'Denied'** means this is a final MN denial status including a fair hearing outcome, if applicable.
3. **MN status = 'Info Needed'** means the MCO must notify appropriate staff to contact TMHP with additional information that is needed for MN determination by TMHP Operations staff.
4. **MN status = 'In Progress'** means the MN process is continuing as expected, but the substantive response may have been transmitted to the MCO as a result of the Medicaid Number Validation process. The Medicaid Number Validation Status field value should be examined for actions that may need to be taken by the MCO. See the 'Medicaid Number Status from TMHP' section in this document for more information.

5. **MN Status = 'Not Started'** means the determination of MN has legitimately not started at TMHP. The substantive response file, in this case, may have been transmitted to the MCO as a result of the Medicaid Number Validation process. See the Medicaid Number Status from TMHP section in this document for more information.

2.6 Medicaid Number Status from TMHP

A validation process will take place when the SK-SAI is received at TMHP. The SK-SAI Substantive Response file will be used to communicate the status of that process.

1. **Medicaid Number Validation Status = 'Valid'** means no further action is required and the MN determination process at TMHP will continue normally for SK-SAIs with a valid Medicaid Number. For SK-SAIs with a plus sign (+) in the Medicaid Number field the MN determination process at TMHP is conducted first so there is no further action being taken at TMHP for this type of form.
2. **Medicaid Number Validation Status = 'Invalid'** the MCO should seek to correct the errors in the Medicaid Number through validation in their systems or contact with HHSC.
3. **Medicaid Number Validation Status = 'In Progress'** the process is continuing as expected. When this status is transmitted, the MCO should examine the MN status field to determine if action is required.
4. **Medicaid Number Validation Status = 'Not Started'** the validation process has legitimately not started at TMHP. The substantive response file in this case may have been transmitted to the MCO as a result of the MN process, and the MCO should examine the MN status field to determine if action is required.

2.7 RUG value from TMHP

The SK-SAI field Z5b 'MDCP RUG Calculation Required?' is used by TMHP to determine if a Resource Utilization Group (RUG) calculation should be completed. Section R of the SK-SAI has mandatory fields that are used at TMHP to calculate the RUG. If these fields do not contain valid data, the RUG value field in the SK-SAI substantive response will be a value of 'invalid'. Otherwise this field will contain the value of the RUG from within the RUG-III 34 code set to be used by the MCO for an MDCP child's Individual Service Plan and payment of some of the services as defined in the LTSS billing matrix.

3 Submission Scenarios

The information in this section describes proper handling of the assessment by the MCO for submission to the State and the expected results for each type of scenario. The scenarios indicate a sequential process with a substantive response from TMHP after each step. However, it is possible that since the Substantive Response file is sent on a daily basis, a single substantive response could be transmitted with all information included for MN Status, Medicaid ID Validation Status and RUG.

3.1 Initial Assessment Scenarios

3.1.1 Basic SK-SAI Scenario

3.1.1.1 MCO actions:

1. Completes SK-SAI required fields and triggers according to the Document Map.
2. Completes the field used to inform TMHP as follows:
    a. A10c = Medicaid number of the individual
    b. A12 = 0 (Initial)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Submits the SK-SAI to TMHP .
4. Handles the Validation Response from TMHP for SK-SAI.
5. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.1.1.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, and indicates ‘accepted’ in the Validation Status field in the validation response file. And stores SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file.
3. Sends the validation response to the MCO.
4. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

3.1.2 CFC Scenario 1: Client has been receiving CFC, already has MN in TMHP LTC Portal (SG 21) active in the last 365 days

3.1.2.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid number of the individual
    b. A12 = 0 (Initial)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Completes the PCAM Module of the SK-SAI.
4. Completes Section P (of the PCAM) for CFC services.
5. Submits the SK-SAI to TMHP.
6. Handles Validation Response file from TMHP.
7. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.1.2.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Note: there is no SK-SAI Substantive Response sent to the MCO for this scenario since MN determination already exists for the individual.

3.1.3 CFC Scenario 2: Client has been receiving or is seeking CFC, but has or needs Level of Care (LOC) through the Local Intellectual Developmental Disability Authority (LIDDA) or Local Mental Health Authority (LMHA)

3.1.3.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid number
    b. A12 = 0 (Initial)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Completes the PCAM
4. Completes Section P (of the PCAM) for CFC services
5. Submits the SK-SAI to TMHP
6. Handles the validation response from TMHP for SK-SAI.
7. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.1.3.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Note: there is no SK-SAI Substantive Response file sent to the MCO for this scenario since Z5a and Z5b are marked as ‘0’.

3.1.4 CFC Scenario 3: Client is seeking CFC, needs MN determination

3.1.4.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.

2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 0 (Initial)
    c. Z5a = 1 (Yes)
    d. Z5b = 0 (No)
2. Completes MN required fields according to the Document Map
3. Completes PCAM
4. Completes PCAM, Section P for CFC services
5. Submits SK-SAI to TMHP
6. Handles the Validation Response from TMHP.
7. Handles Substantive Response from TMHP for MN and Medicaid Number Validation
8. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.1.4.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Performs Medicaid Number validation process.
5. Updates the Medicaid Number Validation status field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medical Necessity Determination
8. Updates the MN status field (and possibly the Notes field) in the substantive response.
9. Sends the substantive response to the MCO.
10. Steps 7 through 9 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.

3.1.5 CFC Scenario 4: Client is seeking CFC but is receiving CFC in IDD Waiver

3.1.5.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 0 (Initial)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Submits SK-SAI to TMHP
4. Handles verification response from TMHP
5. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.1.5.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.

a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.

3. Sends the validation response to the MCO.
4. Note: there is no SK-SAI Substantive Response file sent to the MCO for this scenario since Z5a and Z5b are marked as ‘0’.

3.1.6 MDCP Scenario 1: Current MDCP client, has active MN within the past 365 days (using the MN/LOC assessment not SK-SAI). No change in cost limit sought.

3.1.6.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 0 (Initial)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Validates MN approved status exists within 365 days.
4. Submits SK-SAI to TMHP
5. Handles the Validation Response from TMHP.
6. Completes the SK-ISP Summary Tracking form and narrative form for the individual.
7. Submits the SK-ISP Summary Tracking form (as an X12 278 initial transaction) to TMHP.
8. Handles response from TMHP for SK-ISP.

3.1.6.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates ‘rejected’ in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.1.7 MDCP Scenario 2: Current MDCP client, has active MN within the past 365 days (using the MN/LOC assessment not SK-SAI). Client seeks change in cost limit.

3.1.7.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 0 (Initial)
    c. Z5a = 0 (No)
    d. Z5b = 1 (Yes)
3. Completes MDCP module (Section R) for calculation of RUG
4. Validates an MN/LOC with MN approved status exists within 365 days
5. Submits SK-SAI to TMHP
6. Handles response from TMHP for RUG.
7. Completes the SK-ISP Summary Tracking form and narrative form for the individual.
8. Submits the SK-ISP Summary Tracking form (as an X12 278 initial transaction) to TMHP.
9. Handles response from TMHP for SK-ISP.

3.1.7.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates a RUG based on values in Section R
5. Updates the RUG Value field in the substantive response.
6. Sends the substantive response to MCO.
7. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates ‘rejected’ in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.1.8 MDCP Scenario 3: New MDCP client with Medicaid Number

3.1.8.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 0 (Initial)
    c. Z5a = 1 (Yes)

d. Z5b = 1 (Yes)

3. Completes MN required fields according to the Document Map.
4. Completes MDCP module (Section R) for calculation of RUG.
5. Submits SK-SAI to TMHP.
6. Handles response from TMHP for RUG, MN and Medicaid Number Validation.
7. Completes the SK-ISP Summary Tracking form and narrative form for the individual.
8. Submits the SK-ISP Summary Tracking form (as an X12 278 initial transaction) to TMHP.
9. Handles response from TMHP for SK-ISP.

3.1.8.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates the RUG using Section R values.
5. Updates the RUG Value field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medicaid Number validation process.
8. Updates the Medicaid Number Validation status field in the substantive response.
9. Sends the substantive response to the MCO.
10. Performs Medical Necessity Determination
11. Updates the MN status field (and possibly the Notes field) in the substantive response.
12. Sends the substantive response to the MCO.
13. Steps 10 through 12 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.
14. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.1.9 MDCP Scenario 4: New MDCP client without Medicaid Number (MAO)

3.1.9.1 MCO actions:

1. Confirms a Referral number has been received from HHSC PSU.
2. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
3. Completes the fields to inform TMHP:
    a. A10a = + (plus sign indicating pending Medicaid)
    b. A12 = 0 (Initial)
    c. Z5a = 1 (Yes)
    d. Z5b = 1 (Yes)

4. Completes MN required fields according to the Document Map.
5. Completes MDCP module (Section R) for calculation of RUG.
6. Submits SK-SAI to TMHP.
7. Handles response from TMHP for RUG, MN and Medicaid Number Validation.
8. Completes the SK-ISP Summary Tracking form and narrative form for the individual.
9. Submits the SK-ISP Summary Tracking form (as an X12 278 initial transaction) to TMHP.
10. Handles response from TMHP for SK-ISP.

3.1.9.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates the RUG using Section R values.
5. Updates the RUG Value field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medical Necessity Determination
8. Updates the MN status field (and possibly the Notes field) in the substantive response.
9. Sends the substantive response to the MCO.
10. Steps 7 through 9 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.
11. Performs Medicaid Number validation process.
12. Updates the Medicaid Number Validation status field in the substantive response.
13. Sends the substantive response to the MCO.
14. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.1.10 CFC and MDCP Scenario 1: SK member requesting both CFC and MDCP services

3.1.10.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 0 (Initial Assessment)
    c. Z5a = 1 (Yes)
    d. Z5b = 1 (Yes)
3. Completes the MN fields as defined in the Document Map.
4. Completes the PCAM module.

5. Completes Section P of the PCAM for CFC services.
6. Completes MDCP module (Section R) for calculation of RUG.
7. Submits SK-SAI to TMHP.
8. Handles response from TMHP for RUG and Medicaid Number Validation.
9. Completes the SK-ISP Summary Tracking form and narrative form for the individual.
10. Submits the SK-ISP Summary Tracking form (as an X12 278 initial transaction) to TMHP.
11. Handles response from TMHP for SK-ISP.

3.1.10.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates the RUG using Section R values.
5. Updates the RUG Value field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medical Necessity Determination
8. Updates the MN status field (and possibly the Notes field) in the substantive response.
9. Sends the substantive response to the MCO.
10. Steps 7 through 9 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.
11. Performs Medicaid Number validation process.
12. Updates the Medicaid Number Validation status field in the substantive response.
13. Sends the substantive response to the MCO.
14. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.2 Reassessment Scenarios

3.2.1 Basic SK-SAI Scenario

3.2.1.1 MCO actions:

1. Completes SK-SAI required fields and triggers according to the Document Map.
2. Completes the field used to inform TMHP as follows:
    a. A10c = Medicaid number of the individual
    b. A12 = 1 (Reassessment)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Submits the SK-SAI to TMHP.
4. Handles Validation Response from TMHP.
5. Completes the SK-ISP form for the individual (submission to TMHP is not required).

3.2.1.2 TMHP actions:

1. Receives the submitted SK-SAI.
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, assigns it to the DLN field, and indicates 'accepted' in the Validation Status field in the validation response file. And stores SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the Validation Status field in the validation response file.
2. Sends the validation response to the MCO.
3. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

3.2.2 CFC Scenario 1: Client has been receiving CFC, needs MN annual redetermination; OR Existing client is now seeking CFC for the first time and needs MN

3.2.2.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 1 (Reassessment)
    c. Z5a = 1 (Yes)
    d. Z5b = 0 (No)
3. Completes MN required fields according to the Document Map
4. Completes PCAM
5. Completes PCAM, Section P for CFC services
6. Submits SK-SAI to TMHP
7. Handles response from TMHP for MN and Medicaid Number Validation.
8. Completes the SK-ISP form for the individual (submission to TMHP is not required).

3.2.2.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.

a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.

3. Sends the validation response to the MCO.
4. Performs Medicaid Number validation process.
5. Updates the Medicaid Number Validation status field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medical Necessity Determination
8. Updates the MN status field (and possibly the Notes field) in the substantive response.
9. Sends the substantive response to the MCO.
10. Steps 7 through 9 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.

3.2.3 CFC Scenario 2: Client has been receiving or is seeking CFC, but has/needs LOC through the LIDDA or LMHA

3.2.3.1 MCO actions:

1. Completes SK-SAI required fields and triggers according to the Document Map.
2. Completes the field used to inform TMHP as follows:
    a. A10c = Medicaid number of the individual
    b. A12 = 1 (Reassessment)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Completes PCAM.
4. Completes PCAM, Section P for CFC services.
5. Submits the SK-SAI to TMHP.
6. Handles validation response from TMHP.
7. Completes the SK-ISP form for the individual (submission to TMHP is not required).

3.2.3.2 TMHP actions:

1. Receives the submitted SK-SAI.
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, assigns it to the DLN field, and indicates ‘accepted’ in the Validation Status field in the validation response file. And stores SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file.
2. Sends the validation response to the MCO.
3. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

3.2.4 CFC Scenario 3: Client has been receiving CFC in IDD Waiver

3.2.4.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:

a. A10c = Medicaid Number
b. A12 = 1 (Reassessment)
c. Z5a = 0 (No)
d. Z5b = 0 (No)

3. Submits SK-SAI to TMHP
4. Handles verification response from TMHP
5. Completes the SK-ISP form for the individual (submission to TMHP is not required).

3.2.4.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

3.2.5 MDCP Scenario 1: Current STAR Kids MDCP client

3.2.5.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 1 (Reassessment)
    c. Z5a = 1 (Yes)
    d. Z5b = 1 (Yes)
3. Completes MN required fields according to the Document Map
4. Completes MDCP module (Section R) for calculation of RUG
5. Submits SK-SAI to TMHP
6. Handles response from TMHP for RUG, MN and Medicaid Number Validation.
7. Completes the SK-ISP form for the individual.
8. Submits the SK-ISP Summary Tracking form (as an X12 278 reassessment transaction) to TMHP.
9. Handles response from TMHP for SK-ISP.

3.2.5.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.

4. Calculates the RUG using Section R values.
5. Updates the RUG Value field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medicaid Number validation process.
8. Updates the Medicaid Number Validation status field in the substantive response.
9. Sends the substantive response to the MCO.
10. Performs Medical Necessity Determination
11. Updates the MN status field (and possibly the Notes field) in the substantive response.
12. Sends the substantive response to the MCO.
13. Steps 10 through 12 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.
14. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.2.6 MDCP Scenario 2: Current SK client, new MDCP client with Medicaid Number

3.2.6.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 1 (Reassessment)
    c. Z5a = 1 (Yes)
    d. Z5b = 1 (Yes)
3. Completes MN required fields according to the Document Map
4. Completes MDCP module (Section R) for calculation of RUG
5. Submits SK-SAI to TMHP.
6. Handles response from TMHP for RUG, MN and Medicaid Number Validation.
7. Completes the SK-ISP form for the individual.
8. Submits the SK-ISP Summary Tracking form (as an X12 278 reassessment transaction) to TMHP.
9. Handles response from TMHP for SK-ISP.

3.2.6.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates the RUG using Section R values.
5. Updates the RUG Value field in the substantive response.

6. Sends the substantive response to the MCO.
7. Performs Medicaid Number validation process.
8. Updates the Medicaid Number Validation status field in the substantive response.
9. Sends the substantive response to the MCO.
10. Performs Medical Necessity Determination
11. Updates the MN status field (and possibly the Notes field) in the substantive response.
12. Sends the substantive response to the MCO.
13. Steps 10 through 12 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.
14. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.2.7 CFC and MDCP Scenario 1: SK member for both CFC and MDCP services

3.2.7.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 1 (Reassessment)
    c. Z5a = 1 (Yes)
    d. Z5b = 1 (Yes)
3. Completes MN required fields according to the Document Map.
4. Completes the PCAM module.
5. Completes MDCP module (Section R) for calculation of RUG.
6. Submits SK-SAI to TMHP.
7. Handles response from TMHP for RUG, MN and Medicaid Number Validation.
8. Completes the SK-ISP form for the individual.
9. Submits the SK-ISP X12 278 reassessment transaction to TMHP with only MDCP services.
10. Handles response from TMHP for SK-ISP.

3.2.7.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, indicates 'accepted' in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates the RUG using Section R values.
5. Updates the RUG Value field in the substantive response.
6. Sends the substantive response to the MCO.

7. Performs Medicaid Number validation process.
8. Updates the Medicaid Number Validation status field in the substantive response.
9. Sends the substantive response to the MCO.
10. Performs Medical Necessity Determination.
11. Updates the MN status field (and possibly the Notes field) in the substantive response.
12. Sends the substantive response to the MCO.
13. Steps 10 through 12 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.
14. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

3.3 Significant Change in Status Reassessment (SCSR)

3.3.1 Basic SK-SAI Scenario

3.3.1.1 MCO actions:

1. Completes SK-SAI required fields and triggers according to the Document Map.
2. Completes the field used to inform TMHP as follows:
    a. A10c = Medicaid number of the individual
    b. A12 = 2 (Significant Change in Status Reassessment)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Submits the SK-SAI to TMHP.
4. Handles validation response from TMHP.
5. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.3.1.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted, creates a DLN, assigns it to the DLN field, and indicates 'accepted' in the Validation Status field in the validation response file. And stores SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates 'rejected' in the Validation Status field in the validation response file.
3. Sends the validation response to the MCO.
4. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

3.3.2 CFC Scenario 1: Client has been receiving CFC, already has MN within the past 365 days

One possible reason for this scenario is that there was a significant change in life circumstance or new medical condition that does not impact Medical Necessity and the individual is seeking significant changes in their approved hours for PCS/CFC and/or PDN. In those cases, the MCO would reassess the child in order to establish a new ISP for those services, but does not need a new MN determination. Regardless, the SK-SAI must be submitted to TMHP.

3.3.2.1 MCO actions:

1. Completes SK-SAI required fields and triggers according to the Document Map.

2. Completes the field used to inform TMHP as follows:
    a. A10c = Medicaid number of the individual
    b. A12 = 2 (Significant Change in Status Reassessment)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Completes PCAM
4. Completes PCAM, Section P for CFC services
5. Validates an SK-SAI with MN approved status exists within 365 days
6. Submits the SK-SAI to TMHP.
7. Handles validation response from TMHP.
8. Completes the SK-ISP Summary Tracking form and narrative form for the individual.
9. Submits the SK-ISP Summary Tracking form (as an X12 278 initial transaction) to TMHP.
10. Handles response from TMHP for SK-ISP.

3.3.2.2 TMHP actions:

1. Receives the submitted SK-SAI.
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, assigns it to the DLN field, and indicates 'accepted' in the Validation Status field in the validation response file. And stores SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the Validation Status field in the validation response file.
2. Sends the validation response to the MCO.
3. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

3.3.3 CFC Scenario 2: Current SK client, seeking CFC due to Significant Change in Status, MN needed

3.3.3.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 2 (Significant Change in Status Reassessment)
    c. Z5a = 1 (Yes)
    d. Z5b = 0 (No)
3. Completes MN required fields according to the Document Map
4. Completes PCAM
5. Completes PCAM, Section P for CFC services
6. Submits SK-SAI to TMHP
7. Handles validation response from TMHP.
8. Handles substantive response from TMHP for MN and Medicaid Number Validation.
9. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.3.3.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.

a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.

3. Sends the validation response to the MCO.
4. Performs Medicaid Number validation process.
5. Updates the Medicaid Number Validation status field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medical Necessity Determination.
8. Updates the MN status field (and possibly the Notes field) in the substantive response.
9. Sends the substantive response to the MCO.
10. Steps 7 through 9 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.

3.3.4 CFC Scenario 3: Client has been receiving or is seeking CFC, but has/needs LOC through the LIDDA or LMHA

3.3.4.1 MCO actions:

1. Completes SK-SAI required fields and triggers according to the Document Map.
2. Completes the field used to inform TMHP as follows:
    a. A10c = Medicaid number of the individual
    b. A12 = 2 (Significant Change in Status Reassessment)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Submits the SK-SAI to TMHP.
4. Handles validation response from TMHP.
5. Completes the SK-ISP for the individual (submission to TMHP is not required).

3.3.4.2 TMHP actions:

1. Receives the submitted SK-SAI.
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, assigns it to the DLN field, and indicates ‘accepted’ in the Validation Status field in the validation response file. And stores SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file.
2. Sends the validation response to the MCO.
3. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

3.3.5 MDCP Scenario 1: Current MDCP client reassessed due to Significant Change in Status, seeking new cost limit

3.3.5.1 MCO actions:

1. Completes SK-SAI required fields and triggers according to the Document Map.
2. Completes the field used to inform TMHP as follows:
    a. A10c = Medicaid number of the individual
    b. A12 = 2 (Significant Change in Status Reassessment)

c. Z5a = 0 (No)
d. Z5b = 1 (Yes)

3. Validates an SK-SAI with MN approved status exists within 365 days
4. Completes MDCP module (Section R) for calculation of RUG
5. Submits the SK-SAI to TMHP.
6. Handles validation response from TMHP.
7. Handles response from TMHP for RUG and Medicaid Number Validation.
8. Completes the full SK-ISP and narrative form for the individual once RUG has been received and Medicaid Number is valid (submission to TMHP is not required).

3.3.5.2 TMHP actions:

1. Receives the submitted SK-SAI.
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, assigns it to the DLN field, and indicates 'accepted' in the Validation Status field in the validation response file. And stores SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates 'rejected' in the Validation Status field in the validation response file.
2. Sends the validation response to the MCO.
3. Calculates the RUG using Section R values.
4. Updates the RUG Value field in the substantive response.
5. Sends the substantive response to the MCO.
6. Performs Medicaid Number validation process.
7. Updates the Medicaid Number Validation status field in the substantive response.
8. Sends the substantive response to the MCO.

3.3.6 CFC and MDCP Scenario 1: SK member requesting both CFC and MDCP services

3.3.6.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 2 (Significant Change in Status Reassessment)
    c. Z5a = 0 (No)
    d. Z5b = 1 (Yes)
3. Validates an SK-SAI with MN approved status exists within 365 days
4. Completes MDCP module (Section R) for calculation of RUG
5. Submits SK-SAI to TMHP.
6. Handles response from TMHP for RUG and Medicaid Number Validation.
7. Completes the full SK-ISP and narrative form for the individual once RUG has been received and Medicaid Number is valid (submission to TMHP is not required).

3.3.6.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.

    a. If accepted, creates a DLN, assigns it to the DLN field, indicates ‘accepted’ in the Validation Status field in the validation response file and stores the SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected, indicates ‘rejected’ in the Validation Status field in the validation response file. No DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates the RUG using Section R values.
5. Updates the RUG Value field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medicaid Number validation process.
8. Updates the Medicaid Number Validation status field in the substantive response.
9. Sends the substantive response to the MCO.
10. Later receives the submitted SK-ISP:
    a. Executes schema and business validations.
        i. If accepted, creates a DLN, stores SK-ISP in the TMHP LTC Online Portal database for later access by MCOs and State staff.
        ii. If rejected, indicates ‘rejected’ in the X12 278 validation response.
    b. Sends the X12 278 validation response to the MCO.

4 SK-SAI Correction Scenarios

There are two types of corrections allowed on an SK-SAI, Major and Minor. In both cases, the corrected SK-SAI must be submitted in its entirety, as it will *replace* the previously submitted assessment on the individual as most current (i.e., the MCO may not simply submit corrections to specific fields). A Corrected SK-SAI may only be submitted within 14 days following submission of the SK-SAI. Otherwise, it must be inactivated (see Inactivation Scenario below).
A Major correction to a previously submitted assessment is used to correct Medical Necessity fields on the SK-SAI. The fields used for Medical Necessity are identified on the Document Map.

   a. An MCO may not submit a Major correction on an SK-SAI originally submitted by another MCO. See Transfer Scenarios below.

2. A Minor correction to a previously submitted assessment is used to correct fields other than the Medical Necessity fields on the SK-SAI.
   a. An MCO may not submit a Minor correction on an SK-SAI originally submitted by another MCO. See Transfer Scenarios below.

An SK-SAI minor or major correction should not be submitted to TMHP until after an SK-ISP has been submitted with the following exception:

1. When a referral is received from HHSC PSU for a child off the MDCP interest list and the child does not have an SSN, the SK-SAI will be accepted by TMHP with zeroes in the SSN. The Medical Necessity process will take place with substantive response files being transmitted.
2. However, if an ISP Summary Tracking 278 initial transaction is submitted without a valid SSN it will be rejected.
3. If a valid SSN is received within 14 days of the submission date for the SK-SAI a Minor Correction SK-SAI can be submitted to TMHP with the valid SSN and the same Section Z5a and Z5b values as the originally submitted SK-SAI.
4. If obtaining the SSN takes longer that the allowable 14 days for a correction, the SK-SAI will be rejected at TMHP. To adjust the SSN under this condition the original SK-SAI must be inactivated and a new SK-SAI submitted with the valid SSN at which time the MN process will begin again at TMHP.

4.1 Major Correction

4.1.1 Major Correction Scenario 1: Changes to MN fields on a previously submitted SK-SAI for an MDCP individual.

4.1.1.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
   a. A10c = Medicaid Number
   b. A12 = 4 (Major correction to recent assessment)
   c. Z5a = 1 (Yes)
   d. Z5b = 1 (Yes)
3. Completes MN fields with change(s).
4. Submits to TMHP with DLN field (in the schema) = DLN previously provided by TMHP for the SK-SAI being corrected.
5. Handles validation response from TMHP.

a. If accepted, the original SK-SAI DLN will now be marked as status “Corrected” in the TMHP LTC Online Portal. The newly submitted SK-SAI will be assigned a new DLN and supersede the submitted SK-SAI DLN.

6. Handles substantive response from TMHP for MN, RUG and Medicaid Number Validation.
7. Completes the full SK-ISP for the individual once MN is approved, RUG is calculated and Medicaid Number is valid (submission to TMHP is not required).

4.1.1.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted:
        i. Creates a DLN and assigns it to the DLN field in the Validation Response
        ii. Assigns the DLN submitted by the MCO to the Parent DLN
        iii. Indicates ‘accepted’ in the Validation Status field
        iv. Changes the status of the submitted DLN to ‘Corrected’, thus making it a parent SK-SAI. This DLN is available for access by MCOs and State staff, but is no longer active in the TMHP LTC Online Portal.
        v. Stores the child SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected:
        i. Indicates ‘rejected’ in the Validation Status field in the validation response file.
        ii. Assigns the DLN submitted by the MCO in the Submitted DLN field
        iii. Provides the reason for rejection in the Reject Reason field
        iv. No child DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates RUG using Section R values.
5. Updates the Substantive Response with RUG value.
6. Sends the Substantive Response to the MCO.
7. Performs Medicaid Number validation process on the child DLN.
8. Updates the Medicaid Number Validation status field in the substantive response.
9. Sends the substantive response to the MCO.
10. Performs Medical Necessity Determination on the child DLN.
11. Updates the MN status field (and possibly the Notes field) in the substantive response.
12. Sends the substantive response to the MCO.
13. Steps 10 through 12 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.

4.1.2 Major Correction Scenario 2: Changes to MN fields on a previously submitted SK-SAI for a CFC individual.

4.1.2.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number

b. A12 = 4 (Major correction to recent assessment)
c. Z5a = 1 (Yes)
d. Z5b = 0 (No)

3. Completes MN fields with changes.
4. Submits to TMHP with DLN field (in the schema) = DLN previously provided by TMHP for the SK-SAI being corrected.
5. Handles validation response from TMHP.
    a. If accepted, the original SK-SAI DLN will now be marked as status “Corrected” in the TMHP LTC Online Portal. The newly submitted SK-SAI will be assigned a new DLN and supersede the submitted SK-SAI DLN.
6. Handles substantive response from TMHP for MN and Medicaid Number Validation.

4.1.2.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted:
        i. Creates a DLN and assigns it to the DLN field in the Validation Response,
        ii. Assigns the DLN submitted by the MCO to the Parent DLN
        iii. Indicates ‘accepted’ in the Validation Status field
        iv. Changes the status of the submitted DLN to ‘Corrected’, thus making it a parent SK-SAI. This DLN is available for access by MCOs and State staff, but is no longer active in the TMHP LTC Online Portal.
        v. Stores the child SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected:
        i. Indicates ‘rejected’ in the Validation Status field in the validation response file.
        ii. Assigns the DLN submitted by the MCO in the Submitted DLN field
        iii. Provides the reason for rejection in the Reject Reason field
        iv. No child DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Performs Medicaid Number validation process on the child DLN.
5. Updates the Medicaid Number Validation status field in the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medical Necessity Determination on the child DLN.
8. Updates the MN status field (and possibly the Notes field) in the substantive response.
9. Sends the substantive response to the MCO.
10. Steps 7 through 9 will repeat if additional information is needed from the MCO to arrive at a final determination of Medical Necessity.

4.2 Minor Correction

4.2.1 Minor Correction Scenario 1 (Basic SK-SAI): Changes made to non-MN fields (as defined in Document Map) not including Section R

4.2.1.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:
    a. A10c = Medicaid Number
    b. A12 = 3 (Minor correction to recent assessment)
    c. Z5a = 0 (No)
    d. Z5b = 0 (No)
3. Prevents changes to MN fields for a Minor Correction.
4. Completes any changes to non-MN fields (not Section R for this scenario).
5. Submits to TMHP with DLN field (in the schema) = DLN previously provided by TMHP for the SK-SAI being corrected.
6. Handles validation response from TMHP.
    a. If accepted, the original SK-SAI will now be marked as status “Corrected” in the TMHP LTC Online Portal. The newly submitted SK-SAI will be assigned a new DLN and supersede the previous SK-SAI.

4.2.1.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted:
        i. Creates a DLN and assigns it to the DLN field in the Validation Response,
        ii. Assigns the DLN submitted by the MCO to the Parent DLN
        iii. Indicates ‘accepted’ in the Validation Status field
        iv. Changes the status of the submitted DLN to ‘Corrected’, thus making it a parent SK-SAI. This DLN is available for access by MCOs and State staff, but is no longer active in the TMHP LTC Online Portal.
        v. Stores the child SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected:
        i. Indicates ‘rejected’ in the Validation Status field in the validation response file.
        ii. Assigns the DLN submitted by the MCO to the Submitted DLN field
        iii. Provides the reason for rejection in the Reject Reason field
        iv. No child DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.

4.2.2 Minor Correction Scenario 2 (CFC and MDCP): Changes made to non-MN fields including Section R fields

4.2.2.1 MCO actions:

1. Completes SK-SAI required fields, for a basic SK individual, according to the Document Map.
2. Completes the fields to inform TMHP:

a. A10c = Medicaid Number
b. A12 = 3 (Minor correction to recent assessment)
c. Z5a = 0 (No)
d. Z5b = 1 (Yes)

3. Prevents changes to MN fields for a Minor Correction.
4. Completes changes to non-MN fields including Section R for RUG.
5. Submits to TMHP with DLN field (in the schema) = DLN previously provided by TMHP for the SK-SAI being corrected.
6. Handles validation response from TMHP.
    a. If accepted, the original SK-SAI will now be marked as status “Corrected” in the TMHP LTC Online Portal. The newly submitted SK-SAI will be assigned a new DLN and supersede the previous SK-SAI.
7. Handles Substantive Response from TMHP for the RUG value.
8. Completes the full SK-ISP for the individual (submission to TMHP is not required).
9. Submits the SK-ISP X12 278 transaction to TMHP (for MDCP members only).
10. Handles response from TMHP for SK-ISP.

4.2.2.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted:
        i. Creates a DLN and assigns it to the DLN field in the Validation Response,
        ii. Assigns the DLN submitted by the MCO to the Parent DLN
        iii. Indicates ‘accepted’ in the Validation Status field
        iv. Changes the status of the submitted DLN to ‘Corrected’, thus making it a parent SK-SAI. This DLN is available for access by MCOs and State staff, but is no longer active in the TMHP LTC Online Portal.
        v. Stores the child SK-SAI in the TMHP LTC Online Portal database for later access by MCOs and State staff.
    b. If rejected:
        i. Indicates ‘rejected’ in the Validation Status field in the validation response file.
        ii. Assigns the DLN submitted by the MCO in the Submitted DLN field
        iii. Provides the reason for rejection in the Reject Reason field
        iv. No child DLN is created and the SK-SAI data is not stored in the TMHP system.
3. Sends the validation response to the MCO.
4. Calculates the RUG using data in Section R on the child DLN.
5. Stores the RUG in the RUG Value of the substantive response.
6. Sends the substantive response to the MCO.
7. Performs Medicaid Number validation process on the child DLN.
8. Updates the Medicaid Number Validation status field in the substantive response.
9. Sends the substantive response to the MCO.

5 SK-SAI Inactivation Scenario

An SK-SAI Inactivation should only occur in three cases:

1. When changes to fields in an existing SK-SAI must occur outside the 14-day correction period.
2. If an individual or Legally Authorized Representative (LAR) chooses voluntarily to refuse Medicaid services and such refusal is documented on file with the MCO.
3. If the wrong individual was assessed.

5.1 MCO actions:

1. User identifies SK-SAI to be inactivated in MCO system.
2. Submits SK-SAI to TMHP with:
    a. DLN field (in the schema) = DLN previously provided by TMHP for the SK-SAI to be inactivated.
    b. Form Action (in the schema) = 'Inactivate'
3. Handles validation response from TMHP.
4. Inactivates SK-SAI in MCO system once the Inactivation request was successful at TMHP.
5. For MDCP members only, inactivates associated SK-ISP in MCO system.
6. For MDCP members only, inactivates the SK-ISP using the TMHP LTC Online Portal.
    a. (Note: this function will not be available in the TMHP LTC Online Portal system at go-live (November 1, 2016). The function is currently scheduled to release in January 2017. If an inactivation is needed please contact HHSC PSU.

5.2 TMHP actions:

1. Receives the submitted SK-SAI.
2. Executes schema and business validations.
    a. If accepted:
        i. Assigns the DLN submitted by the MCO to the Inactivated DLN field in the Validation Response file.
        ii. Indicates 'accepted' in the Validation Status field.
        iii. Changes the status of the submitted DLN to 'Form Inactivated'. This DLN is available for access by MCOs and State staff, but is no longer active in the TMHP LTC Online Portal.
    b. If rejected:
        i. Indicates 'rejected' in the Validation Status field in the validation response file.
        ii. Assigns the DLN submitted by the MCO in the Submitted DLN field in the validation response file.
        iii. Provides the reason for rejection in the Reject Reason field in the validation response file.
        iv. The submitted DLN remains active in the TMHP system.
3. Sends the validation response to the MCO.
4. No SK-SAI Substantive Response file is sent to the MCO for this scenario.

6 Transfer Scenario

When a member changes MCOs, the gaining MCO will obtain access through the TMHP LTC Online Portal to the current and all previous SK-SAI forms for that member. Previous SK-SAI forms are not available for download. The losing MCO will no longer have access to these SK-SAI forms. All SK-SAIs and ISPs submitted to the TMHP LTC Online Portal are tied to the Medicaid client.

6.1 MCO actions:

1. The MCO can use an existing SK-SAI present on the TMHP Portal system by searching for the latest SK-SAI and SK-ISP for the incoming member. Note: The data associated with the SK-SAI is not available for download from the TMHP system.
    a. If an SK-SAI is located on the TMHP system, view the A12 field for the type of assessment:
        i. Determine when the next required SK-SAI is due:
            1. If the A12 field is equal to 0 (Initial) or 1 (Reassessment) the next required assessment is 365 days from the A13 Assessment Reference Date field. However, a Significant Change in Status (SCSR) where A12 is equal to 2, can be submitted off-cycle when required.
            2. If the A12 field is equal to 2 (Significant Change in Status Reassessment) search for an SK-SAI where the A12 field is equal to a 0 or 1 and determine the next due date of the assessment as 365 days from the A13 Assessment Reference Date field.
    b. Locate the Medical Necessity (MN) Status at the top of the page:
        i. If the MN status is ‘Not Applicable’ meaning there was no MN determined:
            1. MCO may submit a Reassessment (A12=1) or SCSR (A12=2).
            2. MCO may not submit an Initial, Minor Correction, or Major Correction.
            3. MCO may Inactivate the SK-SAI form on file.
        ii. If the MN status is ‘Approved’
            1. MCO may submit a Reassessment or SCSR.
                a. A Reassessment may not be submitted with “Z5a=1” if the member is not due for MN redetermination.
            2. The MCO may not submit an Initial, Minor Correction, or Major Correction.
            3. The MCO may Inactivate the SK-SAI form on file.
        iii. If the MN status is ‘Not Started’ or ‘In Progress’
            1. The substantive response with the results of MN will be transmitted to your plan code using TxMedCentral.
            2. MCO may not submit an Initial, Reassessment, SCSR, Major Correction, or Minor Correction.
                a. MCO must wait for SK-SAI to reach final disposition before submitting a new SK-SAI.
            3. MCO may Inactivate an SK-SAI form that is in pending status other than the following Fair Hearing form statuses:
                a. Pending Fair Hearing

b. FH Appeal Denied

iv. If the MN status is Denied, then this individual is not eligible for either CFC or MDCP, whichever is designated on the SK-SAI.

7 Appendix A. SK-SAI Schema and Business Validations

The Business Validations executed by TMHP for each SK-SAI submitted by the MCO are listed in the following table. This information is current as of 5/18/2016, but is still undergoing State review. Any changes to these validations will be communicated to the MCOs as a new version of this document.
Note that Table 4 was removed in Version 5.0 since it was duplicate information to Table 3 in this section.

Table 3. Schema & Business Validations

#	Business Validation	Error Message
1	More than 100 SK-SAI forms within the Inbound SK-SAI batch file	'14-The number of forms within the batch file exceeded the limit.' Note: The entire batch file will be rejected and each form will have the same error message stated above in validation response file.
2	Duplicate record id's within the Inbound SK-SAI batch file	'13- Duplicate record id.'
3	Plan code associated to contract number on the Schema for the SK-SAI form is not the same the plan code on the file name of Inbound SK-SAI batch file	'15- Valid Contract Number is required to process the request'
4	Invalid 'Field Identifiers' are present in the Inbound SK-SAI batch file for SK-SAI form	'16- Invalid Field Identifiers'
5	Invalid Value in Form Action Field	'11- Valid value is required on Form Action field to process the request'
6	Invalid Value in Reason for Assessment Field	'12-Valid value is required on Reason for Assessment field to process the request'
7	If schema does not have a DLN AND Form Action = Blank AND Reason for Assessment = 'Initial (0)' or 're-assessment (1)' or 'Significant change in status re-assessment (2)' , then set status of the SK-SAI form to 'Form Submitted' else go to step 8	N/A
8	If schema has a DLN and that is not located within TMHP Portal database , then reject the form else go to step 9	If Form Action = 'Inactivate' then '1- Inactivation Request is rejected. DLN received in Schema is not valid' Else Form Action = Blank, then '7- Correction Request is rejected. DLN received in Schema is not valid'

#	Business Validation	Error Message
9	If schema does not have a DLN AND Form Action = 'Inactivate', then reject the form else go to step 11	'0- Inactivation Request is rejected. Valid DLN is required to process the request'
10	If schema does not have a DLN AND Form Action = Blank AND Reason for Assessment = 'Minor Correction (3)' or 'Major Correction (4)' , then reject the child SK-SAI form else go to step 17	'6- Correction Request is rejected. Valid DLN is required to process the request'
11	If schema has a DLN and that is located within TMHP Portal database AND Form Action = 'Inactivate' AND Form Status = 'Corrected' or 'Inactivated' or 'Invalid/Complete' , then reject the form else go to step 12	'2- Inactivation Request is rejected. DLN should be in valid status to process the request'
12	If schema has a DLN and that is located within TMHP Portal database AND Form Action = 'Inactivate' AND Medicaid ID on DLN = '+' AND MCO = MCO2 submitted the inactivation request for SK-SAI form submitted by MCO1, then reject the form else go to step 13	'3- Inactivation Request is rejected. Forms with '+' sign in Medicaid id field will only be inactivated by the submitter of the form'
13	If schema has a DLN and that is located within TMHP Portal database AND Form Action = 'Inactivate' AND Medicaid ID on DLN = 9 digit Medicaid Id AND MCO = MCO2 submitted the inactivation request for SK-SAI form submitted by MCO1 AND Client Elig. on Current Date = Client is associated to MCO2 on day inactivation request is received AND Form Status = 'FH Appeal Denied' or 'MN Approved' or 'Pending Fair Hearing' or 'Processed Complete' , then reject the form else go to step 14	'4 - Inactivation Request is rejected. Forms in this status will only be inactivated by the submitter of the form'

#	Business Validation	Error Message
14	If schema has a DLN and that is located within TMHP Portal database AND Form Action = 'Inactivate' AND Medicaid ID on DLN = 9 digit Medicaid Id AND MCO = MCO2 submitted the inactivation request for SK-SAI form submitted by MCO1 AND Client Elig. on Current Date = Client does not associated to MCO2 on day inactivation request is received, then reject the form else go to step 9	'5- Inactivation Request is rejected. Member is not associated to the plan code on the date inactivation request is received.'
15	If schema has a DLN and that is located within TMHP Portal database ANDForm Action = 'Inactivate' ANDMedicaid ID on DLN = 9 digit Medicaid Id ANDMCO = MCO1 submitted the inactivation request for SK-SAI form submitted by MCO1 ANDForm Status ≠ 'Corrected' or 'Inactivated' or 'Invalid/Complete' , then set status of a SK-SAI form to 'Inactivated' and stop processing the form.else go to step 15	N/A
16	If schema has a DLN and that is located within TMHP Portal database AND Form Action = 'Inactivate' AND Medicaid ID on DLN = 9 digit Medicaid Id AND MCO = MCO2 submitted the inactivation request for SK-SAI form submitted by MCO1 AND Client Elig on Current Date = Client is associated to MCO2 on day inactivation request is received AND Form Status ≠ 'Corrected' or 'Inactivated' or 'Invalid/Complete' or 'FH Appeal Denied' or 'MN Approved' or 'Pending Fair Hearing' or 'Processed Complete' , then set status of a SK-SAI form to 'Inactivated' and stop processing the form	

#	Business Validation	Error Message
17	If schema has a DLN and that is located within TMHP Portal database AND Form Action = Blank AND Reason for Assessment ≠ 'Minor Correction (3)' or 'Major Correction (4)' , then reject the child form and not change the status of the parent form else go to step 18	'10- DLN is not required to process the request'
18	If schema has a DLN and that is located within TMHP Portal database AND Form Action = Blank AND Reason for Assessment = 'Minor Correction (3)' or 'Major Correction (4)' AND Form Status = 'Corrected' or 'Inactivated' or 'Invalid/Complete' , then reject the child form and not change the status of the parent form else go to step 19	'8- Correction Request is rejected. DLN should be in valid status to process the request'
19	If schema has a DLN and that is located within TMHP Portal database AND Form Action = Blank AND Reason for Assessment = 'Minor Correction (3)' or 'Major Correction (4)' AND Form Status ≠ 'Corrected' or 'Inactivated' or 'Invalid/Complete' AND Child Form = Fails Schema Validation, then reject the child form and not change the status of the parent form else go to step 20	Schema Validation Error messages will be sent for Child form

#	Business Validation	Error Message
20	If schema has a DLN and that is located within TMHP Portal database AND Form Action = Blank AND Reason for Assessment ≠ 'Minor Correction (3)' or 'Major Correction (4)' AND Form Status ≠ 'Corrected' or 'Inactivated' or 'Invalid/Complete' AND Child Form = Passes Schema Validation AND MCO = MCO2 submitted the Correction request for SK-SAI form submitted by MCO1 , then reject the child form and not change the status of the parent form else go to step 21	'9- Correction Request is rejected, Forms submitted by other entity cannot be corrected.'
21	If schema has a DLN and that is located within TMHP Portal database ANDForm Action = Blank AND Reason for Assessment ≠ 'Minor Correction (3)' or 'Major Correction (4)' ANDForm Status ≠ 'Corrected' or 'Inactivated' or 'Invalid/Complete' ANDChild Form = Passes Schema Validation ANDMCO = MCO1 submitted the Correction request for SK-SAI form submitted by MCO1 , then set status of the child SK-SAI form to 'Form Submitted' and parent form to 'Corrected'	N/A

8 Appendix B. SK-SAI Validation Response File Layout

Table 4. Validation Response File layout

Field Name	Required Optional Conditional	Conditional Rule	Data Type	Field Length	Valid Values
Record ID	Required	N/A	Numeric	30	N/A
MCO Unique Identifier	Optional	N/A	Alphanumeric	50	N/A
DLN	Conditional	If Validation status = ‘Accepted’ Form Action = 'Blank'	Numeric	12	DLN Blank
Parent DLN	Conditional	If Reason for Assessment = ‘Minor or Major Correction’ Validation Status = 'Accepted'	Numeric	12	Parent DLN Blank
Inactivated DLN	Conditional	If Form action = ‘Inactivate’ Validation Status = 'Accepted'	Numeric	12	Inactivated DLN Blank
Submitted DLN	Conditional	If ‘Minor or Major Correction Request’ = Rejected OR If 'Inactivation Request' = Rejected	Numeric	12	Original DLN Blank
Validation Status	Required	N/A	Alphanumeric	100	Accepted Rejected

Field Name	Required Optional Conditional	Conditional Rule	Data Type	Field Length	Valid Values
'Reject Reason code' + 'Reject reasons'	Conditional	If Validation status = ‘Rejected’	Alphanumeric	500 per reject reason code and reject reason **Note: Repeater field max 100 reasons will be displayed**	N/A

9 Appendix C. Substantive Response File Layout

Table 5. Substantive Response File layout

Field Name	Required Optional Conditional	Data Type	Field Length (Max field Length)	Valid Values
DLN	Required*	Numeric	12	NA
First Name	Required*	Alphanumeric	15	NA
Middle Initial	Optional	Alphanumeric	1	NA
Last Name	Required*	Alphanumeric	25	NA
Birthdate	Required*	Date	mm/dd/yyyy	NA
SSN	Required*	Numeric	9	NA
Medicaid Number	Required*	Alphanumeric (apply restriction to allow only numeric and the special character '+')	9	NA
RUG value	Optional	Alphanumeric	4	N/A
Notes	Optional	Alphanumeric	500 per Notes Note: max 100 Notes will be displayed	NA
MN Status	Optional	Alphanumeric	100	Approved Denied In Progress Info Needed Not Started Not Applicable Invalid
Medicaid Number Validation Status	Optional	Alphanumeric	100	Valid Invalid In Progress Not Started

10 Appendix D. SK-ISP Processing with TMHP

SK-ISP TMHP System Requirements
Accenture must support receiving 5010 X12 278 transaction requests from STAR Kids and STAR Health MCOs that represent SK-ISP forms.
The system must accept batch X12 278 SK-ISP request files in TXMedCentral from MCO submitters.
The system must allow MCOs to submit X12 278 SK-ISP request files to the following folder located in TXMedCentral:\\...\<MCO>ENC\.... where <MCO> corresponds to the abbreviated MCO name.
The system will accept up to 75 MB for the SK-ISP request files retrieved from the MCO TXMedCentral folders.
EDI will rename the SK-ISP request files retrieved from the MCO TXMedCentral folders with '<fileid>.<filename>.FileTooLarge>' when file size exceeds 75 MB.
EDI will rename the SK-ISP request files retrieved from the MCO TXMedCentral folders with '<fileid>.<filename>.ZeroByte>' when file size equals 0 MB.
The system must accept X12 278 SK-ISP requests in .txt, .dat & .zip file types.
The system must identify and pick up files that are named as ISP.*.txt or ISP.*.dat or ISP.*.Zip from TXMedCentral for processing.
The system must detect when SK-ISP Inbound files are not processed within 24 hours of receipt and will re-process those files.
Accenture must validate inbound X12 278 STAR Kids ISP transaction requests received from STAR Kids and STAR Health MCOs.
EDI must perform HIPAA validation on the SK-ISP X12 278 request files received from MCO submitters.
The Portal services must perform business validation on the SK-ISP X12 278 request files received from MCO submitters. (Refer to the SK-ISP Mapping Document in Appendix E).
Accenture must generate a 5010 X12 278 response to the submitter indicating the outcome of the inbound STAR Kids ISP transaction requests.

SK-ISP TMHP System Requirements
EDI must generate 999, 824, and 278 response files for an X12 278 SK-ISP complete acceptance, when all transactions passed HIPAA validation.
EDI must generate only a negative 999 response file for an X12 278 SK-ISP full file rejection, when all transactions within the request file failed HIPAA validation.
EDI must generate 999, 824, and 278 response files for an X12 278 SK-ISP partial file rejection, when some transactions within the file failed HIPAA validation.
EDI must place the TA1 response file in the following TXMedCentral folder to be picked up by the MCO submitter: \\...\<MCO>ENC\....
The system must name the TA1 response file with the following naming convention: Submitter ID.File ID.TA1
The system must place the 999 response file in the following TXMedCentral folder to be picked up by the MCO submitter: \\...\<MCO>ENC\....
EDI must name the 999 response file with the following naming convention: Submitter ID.File ID.999
Each X12 278 SK-ISP response file will be placed in the following TXMedCentral folder to be picked up by the MCO Submitter: \\...\<MCO>ENC\....
The system must name the X12 278 SK-ISP response file with the following naming convention: Submitter ID.File ID.278
The system must return the DLN in X12 278 SK-ISP response, if no AAA in both 2000E and 2000F with the following logic: 2000E.REF.01 = NT (Administrator's Reference Number) 2000E.REF.02 = ISP care form system DLN
Accenture must include error codes on the 5010 X12 278 response transactions for submitted STAR Kids ISP inbound transactions that fail validation.
The system must generate SK-ISP X12 278 response for rejections with error codes in AAA segment. (Refer to the SK-ISP 278 Mapping Document spreadsheet in Appendix E.)
The system must include the Healthcare Service Review (HCR) segment in SK-ISP X12 278 response with the following logic when there is an (AAA) error found in the 2000F (Services Level): Patient Event Level 2000E.HCR01 = A3 2000E.HCR02 = Leave blank 2000E.HCR03 = 25 Where "A3" and "25" indicate an error was encountered. (Services not considered due to other errors in the request.)

12 Appendix E. ISP Edit Error Messages

Line No.	Edit No.	Portal System Validation	X12 Response	Error Description	Error Type - Fatal, Warning
1	Bx27808000	The Requesting provider MCO Contract number (2010B.NM109) could not be uniquely identified.	2010B.AAA.01 = N 2010B.AAA.03 = 51 2010B.AAA.04 = C	The MCO Contract ID (2010B.NM109/REF02) could not be uniquely identified.	Fatal
2	Bx27808001	The Requesting provider Service Coordinator information is missing (2010B.PER.02).	2010B.AAA.01 = N 2010B.AAA.03 = 15 2010B.AAA.04 = C	The Requesting Provider Service Coordinator (2010B.PER02) information is missing.	Fatal
3	Bx27808002	The MCO County Code information is missing or invalid(2010B.REF.02).	2010B.AAA.01 = N 2010B.AAA.03 = 79 2010B.AAA.04 = C	The MCO County Code value sent in 2010B.REF02 is missing or invalid.	Fatal
4	Bx27808003	Finalized/Approved SK-SAI was not found for the submitted Client identification number (2010C.NM109).	2010C.AAA.01 = N 2010C.AAA.03 = 75 2010C.AAA.04 = C	Finalized/Approved SK-SAI was not found (or) Member could not be identified.	Fatal
5	Bx27808004	Submitted SSN does not match SSN for Medicaid ID submitted. (2010C.REF.02).	2010C.AAA.01 = N 2010C.AAA.03 = 79 2010C.AAA.04 = C	SSN (2010C.REF02) does not match the Applicant/Member's Medicaid ID.	Fatal
6	Bx27808005	Submitted Date of Birth does not match Date of Birth for Medicaid ID submitted. (2010C.DMG.02)	2010C.AAA.01 = N 2010C.AAA.03 = 71 2010C.AAA.04 = C	Date of Birth (2010C.DMG02) submitted is incorrect.	Fatal
7	Bx27808007	For 2000E.UM.02 = "I" or "R" ISP "From Date" must be the 1st day of a month (2000E.DTP.03)	2000E.AAA.01 = N 2000E.AAA.03 = 56 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	ISP From Date (2000E.DTP03) must always be 1st day of a month.	Fatal

Line No.	Edit No.	Portal System Validation	X12 Response	Error Description	Error Type - Fatal, Warning
8	Bx27808011	For 2000E.UM.02 = "I" or "R" ISP "To Date" must always be the last day of a month (2000E.DTP.03)	2000E.AAA.01 = N 2000E.AAA.03 = 56 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	ISP "To Date" (2000E.DTP03) must be the last day of a month.	Fatal
9	Bx27808012	For 2000E.UM.02 = "I" or "R" ISP "From Date" & "To Date" date difference must <= 365 days (2000E.DTP.03)	2000E.AAA.01 = N 2000E.AAA.03 = 56 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	ISP "To Date" must be one year minus one day from ISP "From Date" (2000E.DTP03).	Fatal
10	Bx27808013	For 2000E.UM.02 = "I" or "R" Duplicate or Overlapping ISP form found for the specified "From Date & To Date" (2000E.DTP.03)	2000E.AAA.01 = N 2000E.AAA.03 = 56 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	Duplicate or Overlapping ISP form found for the specified From and To Date (2000E.DTP03).	Fatal
11	Bx27808014	Type Authorization. Only 'Initial' OR 'Reassessment is allowed 2000E.UM.02 must always be "I" or "R"	2000E.AAA.01 = N 2000E.AAA.03 = 33 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	(2000E) UM.02 must always be either "I" or "R".	Fatal
12	Bx27808033	Form type value is missing. Expected value is XSKISP	2000E.AAA.01 = N 2000E.AAA.03 = 33 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	Missing form name in (2000E) MSG01. Expected value is XSKISP.	Fatal

Line No.	Edit No.	Portal System Validation	X12 Response	Error Description	Error Type - Fatal, Warning
13	Bx27808020	Total Estimated Annual Costs must be <= Annual Cost Limit. (Sum of all 2000F.SV102)<= annual cost limit.	2000E.AAA.01 = N 2000E.AAA.03 = 33 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	Total Estimated Cost of all the services exceeds the Annual Cost limit (Sum of all 2000F.SV102).	Fatal
14	Bx27808021	This request does not include a 2000F loop. Accenture system processing requires all requests to include at least one 2000F loop in order to communicate the requested service/procedure code. Please correct and resubmit.	2000E.AAA.01 = N 2000E.AAA.03 = 33 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	Requires at least one service line information (2000F).	Fatal
15	Bx27808022	Must be valid HCPCS code and modifier combination in the SK-ISP Billing Crosswalk table	2000F.AAA.01 = N 2000F.AAA.03 = 33 2000F.AAA.04 = C 2000F.MSG.01 = --> business edit number.	Service Line (2000F.SV1) submitted is not a covered service.	Fatal
16	Bx27808023	Duplicate Procedure Code (2000F.SV101.2) submitted within the same form	2000F.AAA.01 = N 2000F.AAA.03 = 33 2000F.AAA.04 = C 2000F.MSG.01 = --> business edit number.	Duplicate Service Line (2000F.SV1) submitted.	Fatal
17	Bx27808024	The requested procedure code requires a valid modifier (2000F.SV101.3, 2000F.SV101.4, 2000F.SV101.5, 2000F.SV101.6).	2000F.AAA.01 = N 2000F.AAA.03 = 33 2000F.AAA.04 = C 2000F.MSG.01	The requested procedure code requires a valid modifier (2000F.SV1).	Fatal

Line No.	Edit No.	Portal System Validation	X12 Response	Error Description	Error Type - Fatal, Warning
			= --> business edit number.		
18	Bx27808025	Est. Annual Service Units for submitted HCPCS code must be greater than 0. (2000F.SV104)	2000F.AAA.01 = N 2000F.AAA.03 = 33 2000F.AAA.04 = C 2000F.MSG.01 = --> business edit number.	Est. Annual Service Units for submitted HCPCS code must be greater than 0 (2000F.SV104).	Fatal
19	Bx27808026	Est. Annual Service Rate for submitted HCPCS code must be greater than 0. (2000F.SV102)	2000F.AAA.01 = N 2000F.AAA.03 = 33 2000F.AAA.04 = C 2000F.MSG.01 = --> business edit number.	Est. Annual Service Rate for submitted HCPCS code must be greater than 0 (2000F.SV102).	Fatal
20	Bx27808027	During any unexpected exception or portal services down (or) When Portal responds with an invalid Business edit.	2010A.AAA.01 = N 2010A.AAA.03 = 42 2010A.AAA.04 = P	The system is temporarily unavailable to process this request. Please resubmit the request.	Fatal
21	Bx27808028	Incorrect MEWAIVER string.	2010C.AAA.01 = N 2010C.AAA.03 = 78 2010C.AAA.04 = C	Incorrect MEWAIVER string in 2010C.REF02.	Fatal
23	Bx27808032	ISP From Date is not within the approved SK-SAI dates.	2000E.AAA.01 = N 2000E.AAA.03 = 56 2000E.AAA.04 = C 2000E.MSG.01 = --> business edit number.	ISP From Date (2000E.DTP03) is not within the approved SK-SAI dates.	Fatal

13 Document Change Log

Date	Version #	Changes
3/17/2016	1.0	Original Document
4/12/2016	2.0	• Rule clarifications associated with SK-SAI form submissions (by the same MCO and by the gaining MCO on a transfer). • Rule clarification associated with SK-ISP submissions. • Rule clarification associated with SK-SAI corrections, inactivations and submission in a transfer scenario.

4/26/2016	3.0	• Rules clarification for submission of ISP 278 (MDCP only).
		• Rules clarification for posting of ISP Narrative.
		• Update of scenarios reflecting the ISP 278 rule changes
		• Clarifications within the Transfer & Inactivation scenarios
		• TMHP has modified the naming conventions for:
		  ○ SK-SAI XML file
		  ○ Validation response file
		  ○ Substantive response file
		• Rejection Reason Codes for the Validation Response File have been added to Appendix B.

5/18/2016	4.0	• Appendix outlining the SK-ISP 278 processing by TMHP • Appendix describing TMHP SK-ISP edits and error messages • Updated Appendix A with TMHP SK-SAI edits and error messages • Clarifications for SK-ISP submission throughout the document
9/27/2016	5.0	• Add rule to require removal of name suffix prior to submission. • Corrected some errors in the scenarios • Removed Table 4 since it was duplicate information to the table in Appendix A.

APPENDIX II LTC HELP FILE

APPENDIX III LTSS BILLING

LONG TERM SERVICES AND SUPPORT BILLING PROCEDURES

The MCO must require all Providers rendering Long-Term Services and Support (LTSS), with the exception of Atypical Providers,[1] to use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing.

- **Providers using the Paper CMS 1500**
  - Providers billing on paper will provide complete information about the service event and will use the State Assigned Provider Identification (ID) to represent the Provider(s) involved in the service event. The Provider ID (Billing and/or Rendering) will be located in Block 33 on the paper form.
    - If the Billing Provider and the Rendering Provider are the same, then the State Assigned Provider ID will be populated in Block 33.
    - If the Rendering Provider is different than the Billing Provider, then the Billing Provider State Assigned Provider ID will be populated in Block 33, and the Rendering Provider State Assigned Provider ID will be populated in Block 24K.
    - Under specific scenarios the additional usage of Block 17a (Referring Provider (Optional)) and Block 24k can be used to report additional information on Providers that are involved in the service event.

- **Providers using the Electronic HIPAA 837**
  - Providers billing electronically will comply with HIPAA 837 guidelines including the accurate and complete conveyance of information pertaining to the Provider(s) involved in the service event.

- **Atypical Providers**
  - Atypical Providers will submit appropriate documentation to the MCO. The MCO must obtain sufficient documentation from the Atypical Provider to accurately populate a 837 professional encounter. Please refer to the HIPAA-compliant 837 Professional Combined Implementation Guide and the 837 Professional Companion Guide for further information. (See “Claims Processing Requirements” in Chapter 2, Claims, in the UMCM.)

Providers and MCOs will bill and report LTSS in compliance with the STAR Kids Billing Matrix (Matrix).

- **Providers**
  - LTSS Providers must use the “designated position” of the modifiers as indicated on the Matrix when filing claims.

- **MCOs**
  - MCOs must use the “designated position” of the modifiers as indicated on the Matrix when reporting encounters.

[1] Atypical Providers are LTSS providers that render non-health or non-medical services to STAR+PLUS Members. Examples include pest control services and building and supply services.

- **Nursing Facilities**
    - Nursing Facilities services pertaining to a member entering a Nursing Facility will be filed (paper or electronic) through the State's Claims Administrator under Traditional Medicaid (Fee for Service) following the claims submission guidelines applicable to Traditional Medicaid billing.

    - Nursing Facilities services that do not involve a member entering a Nursing Facility (i.e. Respite Care) will conform to normal LTSS billing procedures.

The LTSS Bulletin posted on the Texas Medicaid Health Partnership website (www.tmhp.com) provides additional information and updates.

STAR KIDS LTSS BILLING PROCEDURES

LONG TERM SERVICES AND SUPPORT BILLING PROCEDURES

The MCO must require all Providers rendering Long-Term Services and Support (LTSS), with the exception of Atypical Providers,[1] to use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing.

- **Providers using the Paper CMS 1500**
    - Providers billing on paper will provide complete information about the service event and will use the State Assigned Provider Identification (ID) to represent the Provider(s) involved in the service event. The Provider ID (Billing and/or Rendering) will be located in Block 33 on the paper form.
        - If the Billing Provider and the Rendering Provider are the same, then the State Assigned Provider ID will be populated in Block 33.
        - If the Rendering Provider is different than the Billing Provider, then the Billing Provider State Assigned Provider ID will be populated in Block 33, and the Rendering Provider State Assigned Provider ID will be populated in Block 24K.
        - Under specific scenarios the additional usage of Block 17a (Referring Provider (Optional)) and Block 24k can be used to report additional information on Providers that are involved in the service event.

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    - Providers billing electronically will comply with HIPAA 837 guidelines including the accurate and complete conveyance of information pertaining to the Provider(s) involved in the service event.

- **Atypical Providers**
    - Atypical Providers will submit appropriate documentation to the MCO. The MCO must obtain sufficient documentation from the Atypical Provider to accurately populate a 837 professional encounter. Please refer to the HIPAA-compliant 837 Professional Combined Implementation Guide and the 837 Professional Companion

[1] Atypical Providers are LTSS providers that render non-health or non-medical services to STAR+PLUS Members. Examples include pest control services and building and supply services.

Guide for further information. (See “Claims Processing Requirements” in Chapter 2, Claims, in the UMCM.)

Providers and MCOs will bill and report LTSS in compliance with the STAR Kids Billing Matrix (Matrix).

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- **MCOs**
  - MCOs must use the “designated position” of the modifiers as indicated on the Matrix when reporting encounters.

- **Nursing Facilities**
  - Nursing Facilities services pertaining to a member entering a Nursing Facility will be filed (paper or electronic) through the State's Claims Administrator under Traditional Medicaid (Fee for Service) following the claims submission guidelines applicable to Traditional Medicaid billing.

  - Nursing Facilities services that do not involve a member entering a Nursing Facility (i.e. Respite Care) will conform to normal LTSS billing procedures.

The LTSS Bulletin posted on the Texas Medicaid Health Partnership website (www.tmhp.com) provides additional information and updates.

STAR KIDS LTSS BILLING MATRIX

Service	Procedure Code Qualifier	HCPC Codes	CPT4 Codes	Rev Codes	Mod 1	Mod 2	Mod 3	Mod 4	Units	Service Description	Effective Date
State Plan Services											
Adult Day Care											
	HC	S5101							3-6 Hours = 1 unit, over 6 Hours = 2 units	Day Activities & Health Services (3-6 hours)	November 1, 2016
CCP- Community First Choice for Children under 21											
CFC Attendant Care Only (CFC-PCS)											
	HC	T1019			UD				15 minutes = 1 unit	CFC PCS Attendant care only- Agency Model	November 1, 2016
	HC	T1019			U1				15 minutes = 1 unit	CFC PCS Attendant care only- Service Responsibility Option Model	November 1, 2016
	HC	T1019			U3				15 minutes = 1 unit	CFC PCS Attendant care only- Consumer Directed Services Model	November 1, 2016
Attendant Care and Habilitation (CFC- HAB)											
	HC	T1019			U9				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Agency Model	November 1, 2016
	HC	T1019			U2				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Service Responsibility Option Model	November 1, 2016
	HC	T1019			U4				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Consumer Directed Services Model	November 1, 2016
Emergency Response											
	HC	S5161			U3	U3			1 month = 1 unit	Emergency Response Services (Monthly)	November 1, 2016
	HC	S5160							1 unit per service	Emergency Response Services (Installation and Testing)	November 1, 2016
Personal Care Services (PCS)											
	HC	T1019			U6				15 minutes = 1 unit	PCS - Agency Model	November 1, 2016
	HC	T1019			US				15 minutes = 1 unit	PCS - Service Responsibility Option Model	November 1, 2016
	HC	T1019			UC				15 minutes = 1 unit	PCS - Consumer Directed Services Model	November 1, 2016

	HC	T1019			UA	U6			15 minutes = 1 unit	PCS, BH Condition - Agency Model	November 1, 2016
	HC	T1019			UA	US			15 minutes = 1 unit	PCS, BH Condition - Service Responsibility Option Model	November 1, 2016
	HC	T1019			UA	UC			15 minutes = 1 unit	PCS, BH Condition - Consumer Directed Services Model	November 1, 2016
Nurse Delegation and Supervision											
	HC	G0162							15 minutes= 1 unit	RN Assessment for delegation of PCS or CFC tasks	November 1, 2016
	HC	G0162			U1				15 minutes= 1 unit	RN training and ongoing supervision of delegated tasks	November 1, 2016
Private Duty Nursing											
	HC	T1000			U3				15 minutes= 1 unit	PDN, LVN	November 1, 2016
	HC	T1000			U3	UA			15 minutes= 1 unit	PDN, Specialized LVN	November 1, 2016
	HC	T1000							15 minutes= 1 unit	PDN, RN	November 1, 2016
	HC	T1000			UA				15 minutes= 1 unit	PDN, Specialized RN	November 1, 2016
	HC	T1000			U3	TE			15 minutes= 1 unit	PDN, Independently Enrolled LVN	November 1, 2016
	HC	T1000			U3	UA	TE		15 minutes= 1 unit	PDN, Independently Enrolled Specialized LVN	November 1, 2016
	HC	T1000			TD				15 minutes= 1 unit	PDN, Independently Enrolled RN	November 1, 2016
	HC	T1000			UA	TD			15 minutes= 1 unit	PDN, Independently Enrolled Specialized RN	November 1, 2016
Prescribed Pediatric Extended Care											
	HC	T1025							4.25 hours or more =1 unit	Prescribed Pediatric Extended Care, greater than 4 hours	November 1, 2016
	HC	T1026							1 hour= 1 unit	Prescribed Pediatric Extended Care, up to 4 hours	November 1, 2016
	HC	T2002							1 day = 1 unit	Non-emergency transportation	November 1, 2016
Financial Management Services											

	HC	T2040			U8				Monthly Fee	Financial Management Service Fee, PCS	November 1, 2016
	HC	T2040			U5				Monthly Fee	Financial Management Service Fee, CFC, non- MDCP	November 1, 2016
MDCP Services											
Out-of-Home Respite (Facility)											
	HC	T1005			UA				15 minutes = 1 unit	Level 10: SE3	November 1, 2016
	HC	T1005			U9				15 minutes = 1 unit	Level 9: RAD & SE2	November 1, 2016
	HC	T1005			U8				15 minutes = 1 unit	Level 8: SSC, SE1, &RAC	November 1, 2016
	HC	T1005			U7				15 minutes = 1 unit	Level 7: SSA, SSB, & RAB	November 1, 2016
	HC	T1005			U6				15 minutes = 1 unit	Level 6: RAA	November 1, 2016
	HC	T1005			U5				15 minutes = 1 unit	Level 5: CB2, CC1, & CC2	November 1, 2016
	HC	T1005			U4				15 minutes = 1 unit	Level 4: BB2, CA2, PE1, IB2, PD2, CB1, & PE2	November 1, 2016
	HC	T1005			U3				15 minutes = 1 unit	Level 3: PB2, BB1, PC1, PC2, IB1, CA1, & PD1	November 1, 2016
	HC	T1005			U2				15 minutes = 1 unit	Level 2: BA1, PA2, IA1, PB1, BA2, & IA2	November 1, 2016
	HC	T1005			U1				15 minutes = 1 unit	Level 1: PA1	November 1, 2016
	HC	T1005			UA	U3			15 minutes = 1 unit	Level 10: SE3 with partial vent	November 1, 2016
	HC	T1005			U9	U3			15 minutes = 1 unit	Level 9: RAD & SE2 with partial vent	November 1, 2016
	HC	T1005			U8	U3			15 minutes = 1 unit	Level 8: SE1, & RAC with partial vent	November 1, 2016
	HC	T1005			U7	U3			15 minutes = 1 unit	Level 7: SSA, SSB, RAB, & SSC with partial vent	November 1, 2016
	HC	T1005			U6	U3			15 minutes = 1 unit	Level 6: RAA with partial vent	November 1, 2016
	HC	T1005			U5	U3			15 minutes = 1 unit	Level 5: CC1, & CC2 with partial vent	November 1, 2016
	HC	T1005			U4	U3			15 minutes = 1 unit	Level 4: PE1, IB2, PD2, CB1,PE2, & CB2 with partial vent	November 1, 2016
	HC	T1005			U3	U3			15 minutes = 1 unit	Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 with partial vent	November 1, 2016

	HC	T1005			U2	U3			15 minutes = 1 unit	Level 2: PA2, IA1, PB1, BA2, IA2, and PB2 with partial vent	November 1, 2016
	HC	T1005			U1	U3			15 minutes = 1 unit	Level 1: PA1 & BA1 with partial vent	November 1, 2016
	HC	T1005			UA	U5			15 minutes = 1 unit	Level 10: SE3 with trach	November 1, 2016
	HC	T1005			U9	U5			15 minutes = 1 unit	Level 9: RAD & SE2 with trach	November 1, 2016
	HC	T1005			U8	U5			15 minutes = 1 unit	Level 8: SE1, & RAC with trach	November 1, 2016
	HC	T1005			U7	U5			15 minutes = 1 unit	Level 7: SSA, SSB, RAB, & SSC with trach	November 1, 2016
	HC	T1005			U6	U5			15 minutes = 1 unit	Level 6: RAA with trach	November 1, 2016
	HC	T1005			U5	U5			15 minutes = 1 unit	Level 5: CC1, & CC2 with trach	November 1, 2016
	HC	T1005			U4	U5			15 minutes = 1 unit	Level 4: PE1, IB2, PD2, CB1,PE2, & CB2 with trach	November 1, 2016
	HC	T1005			U3	U5			15 minutes = 1 unit	Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 with trach	November 1, 2016
	HC	T1005			U2	U5			15 minutes = 1 unit	Level 2: PA2, IA1, PB1, BA2, IA2, and PB2 with trach	November 1, 2016
	HC	T1005			U1	U5			15 minutes = 1 unit	Level 1: PA1 & BA1 with trach	November 1, 2016
	HC	T1005			UA	U7			15 minutes = 1 unit	Level 10: SE3 with full vent	November 1, 2016
	HC	T1005			U9	U7			15 minutes = 1 unit	Level 9: RAD & SE2 with full vent	November 1, 2016
	HC	T1005			U8	U7			15 minutes = 1 unit	Level 8: RAB, SSC, SE1, & RAC with full vent	November 1, 2016
	HC	T1005			U7	U7			15 minutes = 1 unit	Level 7: SSA & SSB with full vent	November 1, 2016
	HC	T1005			U6	U7			15 minutes = 1 unit	Level 6: CC2 & RAA with full vent	November 1, 2016
	HC	T1005			U5	U7			15 minutes = 1 unit	Level 5: CB1, PE2, CB2, & CC1 with full vent	November 1, 2016
	HC	T1005			U4	U7			15 minutes = 1 unit	Level 4: PD1, BB2, CA2, PE1, IB2, & PD2 with full vent	November 1, 2016
	HC	T1005			U3	U7			15 minutes = 1 unit	Level 3: BB1, PC1, PC2, IB1, & CA1 with full vent	November 1, 2016
	HC	T1005			U2	U7			15 minutes = 1 unit	Level 2: IA1, PB1, BA2, IA2, & PB2 with full vent	November 1, 2016
	HC	T1005			U1	U7			15 minutes = 1 unit	Level 1: PA1, BA1, & PA2 with full vent	November 1, 2016
Out-of-Home Respite (Non-facility)											
	HC	T2027							15 minutes = 1 unit	Respite Care, Camp Setting	November 1, 2016

In Home Respite											
	HC	H2015			U1				15 minutes= 1 unit	Attendant, Agency Model	November 1, 2016
	HC	H2015			U1	US			15 minutes= 1 unit	Attendant, Service Responsibility Option	November 1, 2016
	HC	H2015			U1	UC			15 minutes= 1 unit	Attendant, CDS Option	November 1, 2016
	HC	H2015			U1	UA			15 minutes= 1 unit	Attendant with RN delegation, Agency Model	November 1, 2016
	HC	H2015			U1	UA	US		15 minutes= 1 unit	Attendant with RN delegation, Service Responsibility Option	November 1, 2016
	HC	H2015			U1	UA	UC		15 minutes= 1 unit	Attendant with RN delegation, CDS Option	November 1, 2016
	HC	H2015			U3				15 minutes= 1 unit	LVN, Agency Model	November 1, 2016
	HC	H2015			U3	US			15 minutes= 1 unit	LVN, Service Responsibility Option	November 1, 2016
	HC	H2015			U3	UC			15 minutes= 1 unit	LVN, CDS Option	November 1, 2016
	HC	H2015			U3	UA			15 minutes= 1 unit	Specialized LVN, Agency Model	November 1, 2016
	HC	H2015			U3	UA	US		15 minutes= 1 unit	Specialized LVN, Service Responsibility Option	November 1, 2016
	HC	H2015			U3	UA	UC		15 minutes= 1 unit	Specialized LVN, CDS Option	November 1, 2016
	HC	H2015			U5				15 minutes= 1 unit	RN, Agency Model	November 1, 2016
	HC	H2015			U5	US			15 minutes= 1 unit	RN, Service Responsibility Option	November 1, 2016
	HC	H2015			U5	UC			15 minutes= 1 unit	RN, CDS Option	November 1, 2016
	HC	H2015			U5	UA			15 minutes= 1 unit	Specialized RN, Agency Model	November 1, 2016
	HC	H2015			U5	UA	US		15 minutes= 1 unit	Specialized RN, Service Responsibility Option	November 1, 2016
	HC	H2015			U5	UA	UC		15 minutes= 1 unit	Specialized RN, CDS Option	November 1, 2016
Flexible Family Support Services											
	HC	H2015			99	U1			15 minutes= 1 unit	Attendant, Agency Model	November 1, 2016
	HC	H2015			99	U1	US		15 minutes= 1 unit	Attendant, Service Responsibility Option	November 1, 2016
	HC	H2015			99	U1	UC		15 minutes= 1 unit	Attendant, CDS Option	November 1, 2016
	HC	H2015			99	U1	UA		15 minutes= 1 unit	Attendant with RN delegation, Agency Model	November 1, 2016

	HC	H2015			99	U1	UA	US	15 minutes= 1 unit	Attendant with RN delegation, Service Responsibility Option	November 1, 2016
	HC	H2015			99	U1	UA	UC	15 minutes= 1 unit	Attendant with RN delegation, CDS Option	November 1, 2016
	HC	H2015			99	U3			15 minutes= 1 unit	LVN, Agency Model	November 1, 2016
	HC	H2015			99	U3	US		15 minutes= 1 unit	LVN, Service Responsibility Option	November 1, 2016
	HC	H2015			99	U3	UC		15 minutes= 1 unit	LVN, CDS Option	November 1, 2016
	HC	H2015			99	U3	UA		15 minutes= 1 unit	Specialized LVN, Agency Model	November 1, 2016
	HC	H2015			99	U3	UA	US	15 minutes= 1 unit	Specialized LVN, Service Responsibility Option	November 1, 2016
	HC	H2015			99	U3	UA	UC	15 minutes= 1 unit	Specialized LVN, CDS Option	November 1, 2016
	HC	H2015			99	U5			15 minutes= 1 unit	RN, Agency Model	November 1, 2016
	HC	H2015			99	U5	US		15 minutes= 1 unit	RN, Service Responsibility Option	November 1, 2016
	HC	H2015			99	U5	UC		15 minutes= 1 unit	RN, CDS Option	November 1, 2016
	HC	H2015			99	U5	UA		15 minutes= 1 unit	Specialized RN, Agency Model	November 1, 2016
	HC	H2015			99	U5	UA	US	15 minutes= 1 unit	Specialized RN, Service Responsibility Option	November 1, 2016
	HC	H2015			99	U5	UA	UC	15 minutes= 1 unit	Specialized RN, CDS Option	November 1, 2016
Financial Management Services											
	HC	T2040			U3				Monthly Fee	Financial Management Service Fee, MDCP	November 1, 2016
	HC	T2040			U4				Monthly Fee	Financial Management Service Fee, CFC and MDCP	November 1, 2016
Adaptive Aids (Waiver)											
	HC	T2028							1 unit per service	Adaptive Aid- NOS	November 1, 2016
	HC	T2029							1 unit per service	Adaptive Aid- Medical Equipment	November 1, 2016
	HC	T2039							1 unit per service	Adaptive Aid- Vehicle Modification	November 1, 2016

Minor Home Modifications											
	HC	S5165							1 unit per service	Minor Home Modifications	November 1, 2016
Transition Assistance Services											
	HC	T2038							1 unit per service	Transition Assistance Services	November 1, 2016
Employment Services											
	HC	H2025							15 minutes= 1 unit	Supported Employment, Agency Model	November 1, 2016
	HC	H2025			US				15 minutes= 1 unit	Supported Employment, Service Responsibility Option	November 1, 2016
	HC	H2025			UC				15 minutes= 1 unit	Supported Employment, CDS Option	November 1, 2016
	HC	H2023							15 minutes= 1 unit	Employment Assistance, Agency Model	November 1, 2016
	HC	H2023			US				15 minutes= 1 unit	Employment Assistance, Service Responsibility Option	November 1, 2016
	HC	H2023			UC				15 minutes= 1 unit	Employment Assistance, CDS Option	November 1, 2016

STAR KIDS CODE CROSSWALK TO TMHP

State Plan Services									
Service	**HCPCS Codes**	**Mod 1**	**Mod 2**	**Mod 3**	**Mod 4**	**Units**	**HHSC Service Description**	**Code in STAR+PLUS**	**Code in TMHP (w/Modifer)**
Adult Day Care									
	S5101					3-6 Hours = 1 unit, over 6 Hours = 2 units	Day Activities & Health Services (3-6 hours)	S5101	S5150

Community First Choice - Attendant Care Only (CFC-PCS)									
	T1019	UD				15 minutes = 1 unit	CFC PCS Attendant care only- Agency Model	Same effective 7/1	Same
	T1019	U1				15 minutes = 1 unit	CFC PCS Attendant care only- Service Responsibility Option Model	Same effective 7/1	Not previously published
	T1019	U3				15 minutes = 1 unit	CFC PCS Attendant care only- Consumer Directed Services Model	Same effective 7/1	Same
Community First Choice - Attendant Care and Habilitation (CFC- HAB)									
	T1019	U9				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Agency Model	Same effective 7/1; possible to see T2021	Same
	T1019	U2				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Service Responsibility Option Model	Same effective 7/1; possible to see T2021	Not previously published
	T1019	U4				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Consumer Directed Services Model	Same effective 7/1; possible to see T2021	Same
Emergency Response									
	S5161	U3	U3			1 month = 1 unit	Emergency Response Services (Monthly)	Same, may have additional modifiers	Not previously published
	S5160					1 unit per service	Emergency Response Services (Installation and Testing)	Same	Not previously published
Personal Care Services (PCS)									
	T1019	U6				15 minutes = 1 unit	PCS - Agency Model	Same, may have additional modifiers; possible to see S5125	Same
	T1019	US				15 minutes = 1 unit	PCS - Service Responsibility Option Model	Not published previously	Not previously published
	T1019	UC				15 minutes = 1 unit	PCS - Consumer Directed Services Model	Same, may have additional modifiers, possible to see S5125	add modifier U7; no UC modifier
	T1019	UA	U6			15 minutes = 1 unit	PCS, BH Condition - Agency Model	Same, may have additional modifiers; possible to see S5125	Same
	T1019	UA	US			15 minutes = 1 unit	PCS, BH Condition - Service Responsibility Option Model	Not previously published	Not previously published
	T1019	UA	UC			15 minutes = 1 unit	PCS, BH Condition - Consumer Directed Services Model	Same, may have additional modifiers; possible to see S5125	add UB, U7 modifiers; no UA, UC modifiers
Nurse Delegation and Supervision									
	G0162					15 minutes= 1 unit	RN Assessment for delegation of PCS or CFC tasks	Same	Same
	G0162	U1				15 minutes= 1 unit	RN training and ongoing supervision of delegated tasks	Same	Same
Private Duty Nursing									

	T1000	U3				15 minutes= 1 unit	PDN, LVN	Same, may have additional modifiers or S9123	T1000 (TE), T1003; no U3 modifier
	T1000	U3	UA			15 minutes= 1 unit	PDN, Specialized LVN	Same, may have additional modifiers or S9123	T1000 (TE), T1003; no U3 modifier
	T1000					15 minutes= 1 unit	PDN, RN	Same, may have additional modifiers or S9123	T1000 (TD), T1002
	T1000	UA				15 minutes= 1 unit	PDN, Specialized RN	Same, may have additional modifiers or S9123	T1000 (TD), T1002
	T1000	U3	TE			15 minutes= 1 unit	PDN, Independently Enrolled LVN	Same, may have additional modifiers or S9123	no U3 modifier
	T1000	U3	UA	TE		15 minutes= 1 unit	PDN, Independently Enrolled Specialized LVN	Same, may have additional modifiers or S9123	no U3 modifier
	T1000	TD				15 minutes= 1 unit	PDN, Independently Enrolled RN	Same, may have additional modifiers or S9123	Same
	T1000	UA	TD			15 minutes= 1 unit	PDN, Independently Enrolled Specialized RN	Same, may have additional modifiers or S9123	Same
Prescribed Pediatric Extended Care									
	T1025					4.25 hours or more =1 unit	Prescribed Pediatric Extended Care, greater than 4 hours	Not previously published	Not previously published
	T1026					1 hour= 1 unit	Prescribed Pediatric Extended Care, up to 4 hours	Not previously published	Not previously published
	T2002					1 day = 1 unit	Non-emergency transportation	Not previously published	Not previously published
Financial Management Services									
	T2040	U8				Monthly Fee	Financial Management Service Fee, PCS	Same, may have additional modifiers	T1019 (U8)
	T2040	U5				Monthly Fee	Financial Management Service Fee, CFC, non-MDCP	Same, may have additional modifiers	T1019 (U5)

STAR KIDS CROSSWALK TO DADS-MDCP

MDCP Services (Formerly DADS Service Group 18)											
Service	**HCPCS Codes**	**Mod 1**	**Mod 2**	**Mod 3**	**Mod 4**	**Units**	**HHSC Service Description**	**Code in STAR+PLUS**	**DADS Texas LTC Local Bill Code**	**DADS Texas LTC Local Service Code**	***Previous* DADS MDCP HCPCS Code**
Out-of-Home Respite (Facility)											
	T1005	UA				15 minutes = 1 unit	Level 10: SE3	N/A	RG105	11F	N/A
	T1005	U9				15 minutes = 1 unit	Level 9: RAD & SE2	N/A	RG101 & RG106	11F	N/A
	T1005	U8				15 minutes = 1 unit	Level 8: SSC, SE1, & RAC	N/A	RG108, RG107, & RG102	11F	N/A
	T1005	U7				15 minutes = 1 unit	Level 7: SSA, SSB, & RAB	N/A	RG110, RG109, & RG103	11F	N/A
	T1005	U6				15 minutes = 1 unit	Level 6: RAA	N/A	RG104	11F	N/A
	T1005	U5				15 minutes = 1 unit	Level 5: CB2, CC1, & CC2	N/A	RG113, RG112, & RG111	11F	N/A
	T1005	U4				15 minutes = 1 unit	Level 4: BB2, CA2, PE1, IB2, PD2, CB1, & PE2	N/A	RG121, RG115, RG126, RG117, RG127, RG114, & RG125	11F	N/A
	T1005	U3				15 minutes = 1 unit	Level 3: PB2, BB1, PC1, PC2, IB1, CA1, & PD1	N/A	RG131, RG122, RG130, RG129, RG118, RG116, & RG128	11F	N/A
	T1005	U2				15 minutes = 1 unit	Level 2: BA1, PA2, IA1, PB1, BA2, & IA2	N/A	RG124, RG133, RG120, RG132, RG123, & RG119	11F	N/A
	T1005	U1				15 minutes = 1 unit	Level 1: PA1	N/A	RG134	11F	N/A
	T1005	UA	U3			15 minutes = 1 unit	Level 10: SE3 with partial vent	N/A	RG305	11FB	H0045

	T1005	U9	U3			15 minutes = 1 unit	Level 9: RAD & SE2 with partial vent	N/A	RG301 & RG306	11FB	H0045
	T1005	U8	U3			15 minutes = 1 unit	Level 8: SE1 & RAC with partial vent	N/A	RG307 & RG302	11FB	H0045
	T1005	U7	U3			15 minutes = 1 unit	Level 7: SSA, SSB, RAB, & SSC with partial vent	N/A	RG310, RG309, RG303, & RG308	11FB	H0045
	T1005	U6	U3			15 minutes = 1 unit	Level 6: RAA with partial vent	N/A	RG304	11FB	H0045
	T1005	U5	U3			15 minutes = 1 unit	Level 5: CC1 & CC2 with partial vent	N/A	RG312 & RG311	11FB	H0045
	T1005	U4	U3			15 minutes = 1 unit	Level 4: PE1, IB2, PD2, CB1, PE2, & CB2 with partial vent	N/A	RG326, RG317, RG327, RG314, RG325, & RG313	11FB	H0045
	T1005	U3	U3			15 minutes = 1 unit	Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 with partial vent	N/A	RG322, RG330, RG329, RG318, RG316, RG328, RG321, & RG315	11FB	H0045
	T1005	U2	U3			15 minutes = 1 unit	Level 2: PA2, IA1, PB1, BA2, IA2, and PB2 with partial vent	N/A	RG333, RG320, RG332, RG323, RG319, & RG331	11FB	H0045
	T1005	U1	U3			15 minutes = 1 unit	Level 1: PA1 & BA1 with partial vent	N/A	RG334 & RG324	11FB	H0045
	T1005	UA	U5			15 minutes = 1 unit	Level 10: SE3 with trach	N/A	RG405	11FC	H0045
	T1005	U9	U5			15 minutes = 1 unit	Level 9: RAD & SE2 with trach	N/A	RG401 & RG406	11FC	H0045
	T1005	U8	U5			15 minutes = 1 unit	Level 8: SE1, & RAC with trach	N/A	RG407 & RG402	11FC	H0045
	T1005	U7	U5			15 minutes = 1 unit	Level 7: SSA, SSB, RAB, & SSC with trach	N/A	RG410, RG409, RG403, & RG408	11FC	H0045
	T1005	U6	U5			15 minutes = 1 unit	Level 6: RAA with trach	N/A	RG404	11FC	H0045
	T1005	U5	U5			15 minutes = 1 unit	Level 5: CC1, & CC2 with trach	N/A	RG412 & RG411	11FC	H0045
	T1005	U4	U5			15 minutes = 1 unit	Level 4: PE1, IB2, PD2, CB1, PE2, & CB2 with trach	N/A	RG426, RG417, RG427, RG414, RG425, & RG413	11FC	H0045

	T1005	U3	U5			15 minutes = 1 unit	Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 with trach	N/A	RG422, RG430, RG42, RG418, RG416, RG428, RG421, RG415	11FC	H0045
	T1005	U2	U5			15 minutes = 1 unit	Level 2: PA2, IA1, PB1, BA2, IA2, and PB2 with trach	N/A	RG433, RG420, RG432, RG423, RG419, & RG431	11FC	H0045
	T1005	U1	U5			15 minutes = 1 unit	Level 1: PA1 & BA1 with trach	N/A	RG434 & RG424	11FC	H0045
	T1005	UA	U7			15 minutes = 1 unit	Level 10: SE3 with full vent	N/A	RG205	11FA	H0045
	T1005	U9	U7			15 minutes = 1 unit	Level 9: RAD & SE2 with full vent	N/A	RG201 & RG206	11FA	H0045
	T1005	U8	U7			15 minutes = 1 unit	Level 8: RAB, SSC, SE1, & RAC with full vent	N/A	RG203, RG208, RG207, & RG202	11FA	H0045
	T1005	U7	U7			15 minutes = 1 unit	Level 7: SSA & SSB with full vent	N/A	RG210 & RG209	11FA	H0045
	T1005	U6	U7			15 minutes = 1 unit	Level 6: CC2 & RAA with full vent	N/A	RG211 & RG204	11FA	H0045
	T1005	U5	U7			15 minutes = 1 unit	Level 5: CB1, PE2, CB2, & CC1 with full vent	N/A	RG214, RG225, RG213, & RG212	11FA	H0045
	T1005	U4	U7			15 minutes = 1 unit	Level 4: PD1, BB2, CA2, PE1, IB2, & PD2 with full vent	N/A	RG228, RG221, RG215, RG226, RG217, & RG227	11FA	H0045
	T1005	U3	U7			15 minutes = 1 unit	Level 3: BB1, PC1, PC2, IB1, & CA1 with full vent	N/A	RG222, RG230, RG229, RG218, & RG216	11FA	H0045
	T1005	U2	U7			15 minutes = 1 unit	Level 2: IA1, PB1, BA2, IA2, & PB2 with full vent	N/A	RG220, RG232, RG223, RG219, & RG231	11FA	H0045
	T1005	U1	U7			15 minutes = 1 unit	Level 1: PA1, BA1, & PA2 with full vent	N/A	RG234, RG224, & RG233	11FA	H0045
Out-of-Home Respite (Non-Facility)											

	T2027					15 minutes = 1 unit	Respite Care, Camp Setting	N/A	G0156	11G	T2037
In Home Respite											
	H2015	U1				15 minutes= 1 unit	Attendant, Agency Model	N/A	G0121	11	S5150
	H2015	U1	US			15 minutes= 1 unit	Attendant, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	U1	UC			15 minutes= 1 unit	Attendant, CDS Option	N/A	G0182, G0183, G6037, G6038, G6039, G6040	11ZV	S5150
	H2015	U1	UA			15 minutes= 1 unit	Attendant with RN delegation, Agency Model	N/A	G0164	11Q	T1005
	H2015	U1	UA	US		15 minutes= 1 unit	Attendant with RN delegation, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	U1	UA	UC		15 minutes= 1 unit	Attendant with RN delegation, CDS Option	N/A	N/A	N/A	N/A
	H2015	U3				15 minutes= 1 unit	LVN, Agency Model	N/A	G0161	11M	S9124
	H2015	U3	US			15 minutes= 1 unit	LVN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	U3	UC			15 minutes= 1 unit	LVN, CDS Option	N/A	G0962, G6007, G6008	11NV	T1003
	H2015	U3	UA			15 minutes= 1 unit	Specialized LVN, Agency Model	N/A	T1033	11MS	T1031
	H2015	U3	UA	US		15 minutes= 1 unit	Specialized LVN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	U3	UA	UC		15 minutes= 1 unit	Specialized LVN, CDS Option	N/A	G0963, G6005, G6006	11NSV	T1031
	H2015	U5				15 minutes= 1 unit	RN, Agency Model	N/A	G0194	11M	S9123
	H2015	U5	US			15 minutes= 1 unit	RN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	U5	UC			15 minutes= 1 unit	RN, CDS Option	N/A	G0960, G0611, G0612	11PV	S9125

	H2015	U5	UA			15 minutes= 1 unit	Specialized RN, Agency Model	N/A	T1032	11MS	T1030
	H2015	U5	UA	US		15 minutes= 1 unit	Specialized RN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	U5	UA	UC		15 minutes= 1 unit	Specialized RN, CDS Option	N/A	G0961, G6009, G6010	11PSV	T1030
Flexible Family Support Services											
	H2015	99	U1			15 minutes= 1 unit	Attendant, Agency Model	N/A	G0168	11U	S5120, T1019, S5130, S5135
	H2015	99	U1	US		15 minutes= 1 unit	Attendant, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	99	U1	UC		15 minutes= 1 unit	Attendant, CDS Option	N/A	G0192, G6021, G6022, G6023, G6024, G6025, G6026, G6027, G6028, G6029, G6030, G6031, G6032, G6033, G6034, G6035, G6036	11UV	T1019, S5135, S5130, S5120, S5135
	H2015	99	U1	UA		15 minutes= 1 unit	Attendant with RN delegation, Agency Model	N/A	G0169	11V	S5125
	H2015	99	U1	UA	US	15 minutes= 1 unit	Attendant with RN delegation, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	99	U1	UA	UC	15 minutes= 1 unit	Attendant with RN delegation, CDS Option	N/A	N/A	N/A	N/A
	H2015	99	U3			15 minutes= 1 unit	LVN, Agency Model	N/A	G0195	11R	S9124
	H2015	99	U3	US		15 minutes= 1 unit	LVN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published

	H2015	99	U3	UC		15 minutes= 1 unit	LVN, CDS Option	N/A	G0964, G6015, G6016	11SV	T1003
	H2015	99	U3	UA		15 minutes= 1 unit	Specialized LVN, Agency Model	N/A	T1037	11RS	T1031
	H2015	99	U3	UA	US	15 minutes= 1 unit	Specialized LVN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	99	U3	UA	UC	15 minutes= 1 unit	Specialized LVN, CDS Option	N/A	G0965, G6013, G6014	11SSV	T1031
	H2015	99	U5			15 minutes= 1 unit	RN, Agency Model	N/A	G0165	11R	S9123
	H2015	99	U5	US		15 minutes= 1 unit	RN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	99	U5	UC		15 minutes= 1 unit	RN, CDS Option	N/A	G0966, G6019, G6020	11TV	T1002
	H2015	99	U5	UA		15 minutes= 1 unit	Specialized RN, Agency Model	N/A	T1036	11RS	T1030
	H2015	99	U5	UA	US	15 minutes= 1 unit	Specialized RN, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2015	99	U5	UA	UC	15 minutes= 1 unit	Specialized RN, CDS Option	N/A	G0967, G6017, G6018	11TSV	T1030
Financial Management Services											
	T2040	U3				Monthly Fee	Financial Management Service Fee, MDCP	N/A	G0225	63V	N/A
	T2040	U4				Monthly Fee	Financial Management Service Fee, CFC and MDCP	N/A	Not previously published	Not previously published	Not previously published
Adaptive Aids (Waiver)											
	T2028					1 unit per service	Adaptive Aid- NOS	N/A	G0500	15	T2028
	T2029					1 unit per service	Adaptive Aid- Medical Equipment	N/A	G0500	15	E2510, E1130, E1399, E1031, E0636, E1902, T2029
	T2039					1 unit per service	Adaptive Aid- Vehicle Modification	N/A	G0500	15	T2039, T2028, E1031

Minor Home Modifications											
	S5165					1 unit per service	Minor Home Modifications	N/A	G0608	16	S5165
Transition Assistance Services											
	T2038					1 unit per service	Transition Assistance Services	N/A	T2038, G0239	53	T2038
Employment Services											
	H2025					15 minutes= 1 unit	Supported Employment, Agency Model	N/A	H2025	37	H2025
	H2025	US				15 minutes= 1 unit	Supported Employment, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2025	UC				15 minutes= 1 unit	Supported Employment, CDS Option	N/A	H2027, G6067, G6068	37V	H2025
	H2023					15 minutes= 1 unit	Employment Assistance, Agency Model	N/A	H2026	54	H2026
	H2023	US				15 minutes= 1 unit	Employment Assistance, Service Responsibility Option	N/A	Not previously published	Not previously published	Not previously published
	H2023	UC				15 minutes= 1 unit	Employment Assistance, CDS Option	N/A	H2029, G6077, G6078	54V	H2026
	NOTE:										
	1. RUGs BC1 and PCE and not used in MDCP and therefore not mapped.										
	2. For CDS, all DADS bill codes were mapped and collapsed into S-K codes, including multiple homemaker, companion care, etc. as well as Taxes and ES/Benefits.										
	3. DADS bill codes that were passed their end date were assumed INACTIVE and NOT mapped (e.g., G0167 - Adjunct RN).										
	4. CDS has not included Attendant with RN delegation option (see Board of Nursing Rules).										
	5. Some DADS bill codes are not mapped (e.g., G0239 - TAS fees) - see "TMHP-DADS Crosswalk to SK Codes" tab to see which codes may not be used.										
	6. Respite Daycare (G0157), Respite Licensed Specialty Care Facility (G0158), and Respite Hospital (G0160) are DADS bill codes, but no category exists that fits them in S-K matrix.										

TMHP-DADS CROSSWALK TO STAR KIDS CODES

			TMHP/DADS CODING											STAR Kids Uniform Bill Coding								
Program Service	**Provider Type**	**Service Description**	**HCPC Code**	**CPT 4**	**REV Code**	**Mod 1**	**Mod 2**	**Mod 3**	**Mod 4**	**DADS Service Code**	**DADS Service Grp Code**	**DADS Bill Code**	**Units**	**HCPC Code**	**CPT 4**	**REV Code**	**Mod 1**	**Mod 2**	**Mod 3**	**Mod 4**	**Units**	**Notes**
State Plan Services																						
Private Duty Nursing	CCP PROVIDER	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TD							1 Unit = 15 min	T1000			TD				1 Unit = 15 min	
	CCP PROVIDER	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TD	UA						1 Unit = 15 min	T1000			UA	TD			1 Unit = 15 min	
	CCP PROVIDER	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TE							1 Unit = 15 min	T1000			U3	TE			1 Unit = 15 min	
	CCP PROVIDER	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TE	UA						1 Unit = 15 min	T1000			U3	UA	TE		1 Unit = 15 min	
	CCP PROVIDER	Services of a qualified nursing aide, up to 15 minutes	T1004										1 Unit = 15 min									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
	HOME HEALTH AGENCY	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TD							1 Unit = 15 min	T1000							1 Unit = 15 min	
	HOME HEALTH AGENCY	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TD	UA						1 Unit = 15 min	T1000			UA				1 Unit = 15 min	
	HOME HEALTH AGENCY	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TE							1 Unit = 15 min	T1000			U3				1 Unit = 15 min	
	HOME HEALTH AGENCY	Private duty / independent nursing service(s) - licensed, up to 15 minutes	T1000			TE	UA						1 Unit = 15 min	T1000			U3	UA			1 Unit = 15 min	
	HOME HEALTH AGENCY	Rn services, up to 15 minutes	T1002										1 Unit = 15 min	T1000							1 Unit = 15 min	
	HOME HEALTH AGENCY	Rn services, up to 15 minutes	T1002			UA							1 Unit = 15 min	T1000							1 Unit = 15 min	
	HOME HEALTH AGENCY	Lpn/lvn services, up to 15 minutes	T1003										1 Unit = 15 min	T1000			U3				1 Unit = 15 min	

	HOME HEALTH AGENCY	Lpn/lvn services, up to 15 minutes	T1003			UA							1 Unit = 15 min	T1000			U3				1 Unit = 15 min	
	HOME HEALTH AGENCY	Services of a qualified nursing aide, up to 15 minutes	T1004										1 Unit = 15 min									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
	TB CLINIC - GROUP	Rn services, up to 15 minutes	T1002										1 Unit = 15 min	T1000							1 Unit = 15 min	
	TB CLINIC - GROUP	Lpn/lvn services, up to 15 minutes	T1003										1 Unit = 15 min	T1000			U3				1 Unit = 15 min	
	TB CLINIC - INDIVIDUAL	Rn services, up to 15 minutes	T1002										1 Unit = 15 min	T1000							1 Unit = 15 min	
	TB CLINIC - INDIVIDUAL	Lpn/lvn services, up to 15 minutes	T1003										1 Unit = 15 min	T1000			U3				1 Unit = 15 min	
Personal Care Services and CFC Habilitation/PCS	CCP - PCS	PCS, per 15 min, CFC attendant care only, CDS option	T1019			U3							1 Unit = 15 min	T1019			U3				1 Unit = 15 min	
	CCP - PCS	PCS, per 15 min, CFC habilitation, CDS option (this is billed when person needs habilitation only or both PCS & habilitaiton)	T1019			U4							1 Unit = 15 min	T1019			U4				1 Unit = 15 min	
	CCP - PCS	CFC CDS Administration Fee - once per month	T1019			U5							1 Unit = 1 month	T1019			U5				1 Unit = 1 month	
	CCP - PCS & Home Health Agency	PCS, per 15 min (non-CFC, non-CDS)	T1019			U6							1 Unit = 15 min	T1019			U6				1 Unit = 15 min	
	CCP - PCS & Home Health Agency	PCS, per 15 min, CDS option (non-CFC)	T1019			U7							1 Unit = 15 min	T1019			UC				1 Unit = 15 min	Note same rate as CDS option if person is CFC (U3)
	CCP - PCS & Home Health Agency	CDS Administration Fee - once per month (non-CFC)	T1019			U8							1 Unit = 1 month	T2040			U8				1 Unit = 1 month	Note same rate as CDS option if person is CFC (U5)
	CCP - PCS & Home Health Agency	PCS, per 15 min, CFC habilitation (this is billed when person needs habilitation only or both PCS & habilitaiton, non-CDS)	T1019			U9							1 Unit = 15 min	T1019			U9				1 Unit = 15 min	Note same rate as non-CFC option if person has a BH condition (UA)
	HOME HEALTH AGENCY	PCS, per 15 min, person has BH condition (non-CFC, non-CDS)	T1019			UA							1 Unit = 15 min	T1019			UA	U6			1 Unit = 15 min	

	HOME HEALTH AGENCY	PCS, per 15 min, person has BH condition, CDS option (non-CFC)	T1019			UB							1 Unit = 15 min	T1019			UA	UC			1 Unit = 15 min	Note same rate as CDS option if person is CFC (U4)
	HOME HEALTH AGENCY	PCS, per 15 min, CFC attendant care only (non-CDS option)	T1019			UD							1 Unit = 15 min	T1019			UD				1 Unit = 15 min	Note same rate as non-CFC, non CDS (U6)
Day Activity Health Services	DAHS Facility	Activity Center offering meals, limited health services, activities and transportation w/in 15 miles of the facility	S5101								3,7,18	C0129;C0200;CO202;C0210	1 unit = 3-6 hours; 2 units = over 6 hours	S5101							1 unit = 3-6 hours; 2 units = over 6 hours	
Medically Dependent Children's Program (MDCP)			**HCPC Code**	**CPT 4**	**REV Code**	**Mod 1**	**Mod 2**	**Mod 3**	**Mod 4**	**DADS Service Code**	**DADS Service Grp Code**	**DADS Bill Code**	**Units**	**HCPC Code**	**CPT 4**	**REV Code**	**Mod 1**	**Mod 2**	**Mod 3**	**Mod 4**	**Units**	
Respite In-Home		RESPITE - PERSONAL ASSISTANCE SERVICES	S5150		0662					11	18	G0121	1 unit = 1 hour	H2015			U1				1 Unit = 15 min	
		RESPITE - PERSONAL ASSISTANCE SERVICES	S5150							11	18	G0121	1 unit = 1 hour	H2015			U1				1 Unit = 15 min	
		RESPITE - HCSS (RN/LVN) LVN	S9124					TE		11M	18	G0161	1 unit = 1 hour	H2015			U3				1 Unit = 15 min	
		RESPITE - HCSS (RN/LVN) RN	S9123					TD		11M	18	G0194	1 unit = 1 hour	H2015			U5				1 Unit = 15 min	
		RESPITE - LVN	T1003		0661			TE		11N	18	G0162	1 unit = 1 hour	H2015			U3				1 Unit = 15 min	
		RESPITE - RN	T1002		0661			TD		11P	18	G0163	1 unit = 1 hour	H2015			U5				1 Unit = 15 min	
		SPECIALIZED RESPITE - RN	T1030				TG	TD		11PS	18	T1030	1 unit = 1 hour	H2015			U5	UA			1 Unit = 15 min	
		RESPITE - PAS DELEGATED	T1005		0662					11Q	18	G0164	1 unit = 1 hour	H2015			U1	UA			1 Unit = 15 min	
		RESPITE - PAS DELEGATED	T1005							11Q	18	G0164	1 unit = 1 hour	H2015			U1	UA			1 Unit = 15 min	

		SPECIALIZED RESPITE - HCSS RN	T1030				TG	TD		11MS	18	T1032	1 unit = 1 hour	H2015			U5	UA			1 Unit = 15 min	
		SPECIALIZED RESPITE - HCSS LVN	T1031				TG	TE		11MS	18	T1033	1 unit = 1 hour	H2015			U3	UA			1 Unit = 15 min	
		CDS SPECIALIZED RESPITE - LVN	T1031						TE	11NSV	18	G0963	1 unit = 1 hour	H2015			U3	UA	UC		1 Unit = 15 min	
		CDS SPECIALIZED RESPITE - LVN - TAXES	T1031					UG	TE		18	G6005	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS SPECIALIZED RESPITE - LVN - ES/BENEFITS	T1031					UF	TE		18	G6006	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		SPECIALIZED RESPITE - LVN	T1031				TG	TE		11NS	18	T1031	1 unit = 1 hour	H2015			U3				1 Unit = 15 min	
		CDS RESPITE - LVN	T1003				TE			11NV	18	G0962	1 unit = 1 hour	H2015			U3	UC			1 Unit = 15 min	
		CDS RESPITE - LVN - TAXES	T1003				TE	UG			18	G6007	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS RESPITE - LVN - ES/BENEFITS	T1003				TE	UF			18	G6008	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS SPECIALIZED RESPITE RN	T1030						TD	11PSV	18	G0961	1 unit = 1 hour	H2015			U5	UA	UC		1 Unit = 15 min	
		CDS SPECIALIZED RESPITE - RN - TAXES	T1030					UG	TD		18	G6009	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS SPECIALIZED RESPITE - RN - ES/BENEFITS	T1030					UF	TD		18	G6010	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS RESPITE IN HOME RN	S9125							11PV	18	T1030	1 unit = 1 hour	H2015			U5	UA	UC		1 Unit = 15 min	
		CDS RESPITE IN HOME RN - TAXES	S9125					UG			18	G6009	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS RESPITE IN HOME RN - ES/BENEFITS	S9125					UF			18	G6010	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK

		CDS - RESPITE-IN-HOME - IND	S5150		0662				UB	11ZV	18	G0182	1 unit = 1 hour	H2015			U1	UC			1 Unit = 15 min	NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - IND.	S5150						UB	11ZV	18	G0182	1 unit = 1 hour	H2015			U1	UC			1 Unit = 15 min	NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - IND.	S5150						UB	11ZV	18	G0182	1 unit = 1 hour	H2015			U1	UC			1 Unit = 15 min	NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - AGENCY	S5150		0662				UC	11ZV	18	G0183	1 unit = 1 hour	H2015			U1	UC			1 Unit = 15 min	NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - AGENCY	S5150						UC	11ZV	18	G0183	1 unit = 1 hour	H2015			U1	UC			1 Unit = 15 min	NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - IND - TAXES	S5150		0662			UG	UB		18	G6037	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - IND - ES/BENEFITS	S5150		0662			UF	UB		18	G6038	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - IND - TAXES	S5150					UG	UB		18	G6037	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - RESPITE-IN-HOME - IND - ES/BENEFITS	S5150					UF	UB		18	G6038	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
Respite Out of Home		RESPITE - DAY CARE/LICENSED CHILD CARE FACILITY	T2026		0663					11H	18	T2026	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE - LICENSED SPECIAL CARE FACILITY	S5150		0663					11J	18	T2026	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE - CAMP	T2037		0663					11G	18	G0156	1 unit = 1 hour	T2027							1 Unit = 15 min	
		RESPITE-HOSPITAL			0660						18	G0160	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE-HOSPITAL			0660						18	G0160	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE NF - RAD			0663					11F	18	RG101	1 unit = 1 hour	T1005			U9				1 Unit = 15 min	

		RESPITE NF - RAC			0663					11F	18	RG102	1 unit = 1 hour	T1005			U8				1 Unit = 15 min	
		RESPITE NF - RAB			0663					11F	18	RG103	1 unit = 1 hour	T1005			U7				1 Unit = 15 min	
		RESPITE NF - RAA			0663					11F	18	RG104	1 unit = 1 hour	T1005			U6				1 Unit = 15 min	
		RESPITE NF - SE3			0663					11F	18	RG105	1 unit = 1 hour	T1005			UA				1 Unit = 15 min	
		RESPITE NF - SE2			0663					11F	18	RG106	1 unit = 1 hour	T1005			U9				1 Unit = 15 min	
		RESPITE NF - SE1			0663					11F	18	RG107	1 unit = 1 hour	T1005			U8				1 Unit = 15 min	
		RESPITE NF - SSC			0663					11F	18	RG108	1 unit = 1 hour	T1005			U8				1 Unit = 15 min	
		RESPITE NF - SSB			0663					11F	18	RG109	1 unit = 1 hour	T1005			U7				1 Unit = 15 min	
		RESPITE NF - SSA			0663					11F	18	RG110	1 unit = 1 hour	T1005			U7				1 Unit = 15 min	
		RESPITE NF - CC2			0663					11F	18	RG111	1 unit = 1 hour	T1005			U5				1 Unit = 15 min	
		RESPITE NF - CC1			0663					11F	18	RG112	1 unit = 1 hour	T1005			U5				1 Unit = 15 min	
		RESPITE NF - CB2			0663					11F	18	RG113	1 unit = 1 hour	T1005			U5				1 Unit = 15 min	
		RESPITE NF - CB1			0663					11F	18	RG114	1 unit = 1 hour	T1005			U4				1 Unit = 15 min	
		RESPITE NF - CA2			0663					11F	18	RG115	1 unit = 1 hour	T1005			U4				1 Unit = 15 min	

		RESPITE NF - CA1			0663					11F	18	RG116	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	
		RESPITE NF - IB2			0663					11F	18	RG117	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	
		RESPITE NF - IB1			0663					11F	18	RG118	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	
		RESPITE NF - IA2			0663					11F	18	RG119	1 unit = 1 hour	T1005			U2				1 Unit = 15 min	
		RESPITE NF - IA1			0663					11F	18	RG120	1 unit = 1 hour	T1005			U2				1 Unit = 15 min	
		RESPITE NF - BB2			0663					11F	18	RG121	1 unit = 1 hour	T1005			U4				1 Unit = 15 min	
		RESPITE NF - BB1			0663					11F	18	RG122	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	
		RESPITE NF - BA2			0663					11F	18	RG123	1 unit = 1 hour	T1005			U2				1 Unit = 15 min	
		RESPITE NF - BA1			0663					11F	18	RG124	1 unit = 1 hour	T1005			U2				1 Unit = 15 min	
		RESPITE NF - PE2			0663					11F	18	RG125	1 unit = 1 hour	T1005			U4				1 Unit = 15 min	
		RESPITE NF - PE1			0663					11F	18	RG126	1 unit = 1 hour	T1005			U4				1 Unit = 15 min	
		RESPITE NF - PD2			0663					11F	18	RG127	1 unit = 1 hour	T1005			U4				1 Unit = 15 min	
		RESPITE NF - PD1			0663					11F	18	RG128	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	
		RESPITE NF - PC2			0663					11F	18	RG129	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	

		RESPITE NF - PC1			0663					11F	18	RG130	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	
		RESPITE NF - PB2			0663					11F	18	RG131	1 unit = 1 hour	T1005			U3				1 Unit = 15 min	
		RESPITE NF - PB1			0663					11F	18	RG132	1 unit = 1 hour	T1005			U2				1 Unit = 15 min	
		RESPITE NF - PA2			0663					11F	18	RG133	1 unit = 1 hour	T1005			U2				1 Unit = 15 min	
		RESPITE NF - PA1			0663					11F	18	RG134	1 unit = 1 hour	T1005			U1				1 Unit = 15 min	
		RESPITE NF - BC1			0663					11F	18	RG135	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE NF - PCE			0663					11F	18	RG136	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE NF W/24 HOUR VENT RAD	H0045		0663		KX			11FA	18	RG201	1 unit = 1 hour	T1005			U9	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT RAC	H0045		0663		KX			11FA	18	RG202	1 unit = 1 hour	T1005			U8	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT RAB	H0045		0663		KX			11FA	18	RG203	1 unit = 1 hour	T1005			U8	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT RAA	H0045		0663		KX			11FA	18	RG204	1 unit = 1 hour	T1005			U6	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT SE3	H0045		0663		KX			11FA	18	RG205	1 unit = 1 hour	T1005			UA	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT SE2	H0045		0663		KX			11FA	18	RG206	1 unit = 1 hour	T1005			U9	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT SE1	H0045		0663		KX			11FA	18	RG207	1 unit = 1 hour	T1005			U8	U7			1 Unit = 15 min	

		RESPITE NF W/24 HOUR VENT SSC	H0045		0663		KX			11FA	18	RG208	1 unit = 1 hour	T1005			U8	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT SSB	H0045		0663		KX			11FA	18	RG209	1 unit = 1 hour	T1005			U7	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT SSA	H0045		0663		KX			11FA	18	RG210	1 unit = 1 hour	T1005			U7	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT CC2	H0045		0663		KX			11FA	18	RG211	1 unit = 1 hour	T1005			U6	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT CC1	H0045		0663		KX			11FA	18	RG212	1 unit = 1 hour	T1005			U5	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT CB2	H0045		0663		KX			11FA	18	RG213	1 unit = 1 hour	T1005			U5	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT CB1	H0045		0663		KX			11FA	18	RG214	1 unit = 1 hour	T1005			U5	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT CA2	H0045		0663		KX			11FA	18	RG215	1 unit = 1 hour	T1005			U4	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT CA1	H0045		0663		KX			11FA	18	RG216	1 unit = 1 hour	T1005			U3	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT IB2	H0045		0663		KX			11FA	18	RG217	1 unit = 1 hour	T1005			U4	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT IB1	H0045		0663		KX			11FA	18	RG218	1 unit = 1 hour	T1005			U3	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT IA2	H0045		0663		KX			11FA	18	RG219	1 unit = 1 hour	T1005			U2	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT IA1	H0045		0663		KX			11FA	18	RG220	1 unit = 1 hour	T1005			U2	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT BB2	H0045		0663		KX			11FA	18	RG221	1 unit = 1 hour	T1005			U4	U7			1 Unit = 15 min	

		RESPITE NF W/24 HOUR VENT BB1	H0045		0663		KX			11FA	18	RG222	1 unit = 1 hour	T1005			U3	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT BA2	H0045		0663		KX			11FA	18	RG223	1 unit = 1 hour	T1005			U2	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT BA1	H0045		0663		KX			11FA	18	RG224	1 unit = 1 hour	T1005			U1	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PE2	H0045		0663		KX			11FA	18	RG225	1 unit = 1 hour	T1005			U5	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PE1	H0045		0663		KX			11FA	18	RG226	1 unit = 1 hour	T1005			U4	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PD2	H0045		0663		KX			11FA	18	RG227	1 unit = 1 hour	T1005			U4	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PD1	H0045		0663		KX			11FA	18	RG228	1 unit = 1 hour	T1005			U4	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PC2	H0045		0663		KX			11FA	18	RG229	1 unit = 1 hour	T1005			U3	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PC1	H0045		0663		KX			11FA	18	RG230	1 unit = 1 hour	T1005			U3	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PB2	H0045		0663		KX			11FA	18	RG231	1 unit = 1 hour	T1005			U2	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PB1	H0045		0663		KX			11FA	18	RG232	1 unit = 1 hour	T1005			U2	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PA2	H0045		0663		KX			11FA	18	RG233	1 unit = 1 hour	T1005			U1	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT PA1	H0045		0663		KX			11FA	18	RG234	1 unit = 1 hour	T1005			U1	U7			1 Unit = 15 min	
		RESPITE NF W/24 HOUR VENT BC1	H0045		0663		KX			11FA	18	RG235	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK

		RESPITE NF W/24 HOUR VENT PCE	H0045		0663		KX			11FA	18	RG236	1 unit = 1 hour										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE NF W/<24 HOUR VENT RAD	H0045		0663		KX			11FB	18	RG301	1 unit = 1 hour	T1005			U9	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT RAC	H0045		0663		KX			11FB	18	RG302	1 unit = 1 hour	T1005			U8	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT RAB	H0045		0663		KX			11FB	18	RG303	1 unit = 1 hour	T1005			U8	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT RAA	H0045		0663		KX			11FB	18	RG304	1 unit = 1 hour	T1005			U6	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT SE3	H0045		0663		KX			11FB	18	RG305	1 unit = 1 hour	T1005			UA	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT SE2	H0045		0663		KX			11FB	18	RG306	1 unit = 1 hour	T1005			U9	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT SE1	H0045		0663		KX			11FB	18	RG307	1 unit = 1 hour	T1005			U8	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT SSC	H0045		0663		KX			11FB	18	RG308	1 unit = 1 hour	T1005			U7	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT SSB	H0045		0663		KX			11FB	18	RG309	1 unit = 1 hour	T1005			U7	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT SSA	H0045		0663		KX			11FB	18	RG310	1 unit = 1 hour	T1005			U7	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT CC2	H0045		0663		KX			11FB	18	RG311	1 unit = 1 hour	T1005			U5	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT CC1	H0045		0663		KX			11FB	18	RG312	1 unit = 1 hour	T1005			U5	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT CB2	H0045		0663		KX			11FB	18	RG313	1 unit = 1 hour	T1005			U4	U3			1 Unit = 15 min	

		RESPITE NF W/<24 HOUR VENT CB1	H0045		0663		KX			11FB	18	RG314	1 unit = 1 hour	T1005			U4	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT CA2	H0045		0663		KX			11FB	18	RG315	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT CA1	H0045		0663		KX			11FB	18	RG316	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT IB2	H0045		0663		KX			11FB	18	RG317	1 unit = 1 hour	T1005			U4	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT IB1	H0045		0663		KX			11FB	18	RG318	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT IA2	H0045		0663		KX			11FB	18	RG319	1 unit = 1 hour	T1005			U2	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT IA1	H0045		0663		KX			11FB	18	RG320	1 unit = 1 hour	T1005			U2	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT BB2	H0045		0663		KX			11FB	18	RG321	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT BB1	H0045		0663		KX			11FB	18	RG322	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT BA2	H0045		0663		KX			11FB	18	RG323	1 unit = 1 hour	T1005			UJ 2	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT BA1	H0045		0663		KX			11FB	18	RG324	1 unit = 1 hour	T1005			U1	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PE2	H0045		0663		KX			11FB	18	RG325	1 unit = 1 hour	T1005			U4	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PE1	H0045		0663		KX			11FB	18	RG326	1 unit = 1 hour	T1005			U4	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PD2	H0045		0663		KX			11FB	18	RG327	1 unit = 1 hour	T1005			U4	U3			1 Unit = 15 min	

		RESPITE NF W/<24 HOUR VENT PD1	H0045		0663		KX			11FB	18	RG328	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PC2	H0045		0663		KX			11FB	18	RG329	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PC1	H0045		0663		KX			11FB	18	RG330	1 unit = 1 hour	T1005			U3	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PB2	H0045		0663		KX			11FB	18	RG331	1 unit = 1 hour	T1005			U2	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PB1	H0045		0663		KX			11FB	18	RG332	1 unit = 1 hour	T1005			U2	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PA2	H0045		0663		KX			11FB	18	RG333	1 unit = 1 hour	T1005			U2	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT PA1	H0045		0663		KX			11FB	18	RG334	1 unit = 1 hour	T1005			U1	U3			1 Unit = 15 min	
		RESPITE NF W/<24 HOUR VENT BC1	H0045		0663		KX			11FB	18	RG335	1 unit = 1 hour									
		RESPITE NF W/<24 HOUR VENT PCE	H0045		0663		KX			11FB	18	RG336	1 unit = 1 hour									
		RESPITE NF W/PEDIATRIC TRACH RAD	H0045		0663		KX			11FC	18	RG401	1 unit = 1 hour	T1005			U9	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH RAC	H0045		0663		KX			11FC	18	RG402	1 unit = 1 hour	T1005			U8	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH RAB	H0045		0663		KX			11FC	18	RG403	1 unit = 1 hour	T1005			U7	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH RAA	H0045		0663		KX			11FC	18	RG404	1 unit = 1 hour	T1005			U6	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH SE3	H0045		0663		KX			11FC	18	RG405	1 unit = 1 hour	T1005			UA	U5			1 Unit = 15 min	

		RESPITE NF W/PEDIATRIC TRACH SE2	H0045		0663		KX			11FC	18	RG406	1 unit = 1 hour	T1005			U9	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH SE1	H0045		0663		KX			11FC	18	RG407	1 unit = 1 hour	T1005			U8	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH SSC	H0045		0663		KX			11FC	18	RG408	1 unit = 1 hour	T1005			U7	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH SSB	H0045		0663		KX			11FC	18	RG409	1 unit = 1 hour	T1005			U7	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH SSA	H0045		0663		KX			11FC	18	RG410	1 unit = 1 hour	T1005			U7	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH CC2	H0045		0663		KX			11FC	18	RG411	1 unit = 1 hour	T1005			U5	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH CC1	H0045		0663		KX			11FC	18	RG412	1 unit = 1 hour	T1005			U5	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH CB1	H0045		0663		KX			11FC	18	RG413	1 unit = 1 hour	T1005			U4	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH CB1	H0045		0663		KX			11FC	18	RG414	1 unit = 1 hour	T1005			U4	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH CA2	H0045		0663		KX			11FC	18	RG415	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH CA1	H0045		0663		KX			11FC	18	RG416	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH IB2	H0045		0663		KX			11FC	18	RG417	1 unit = 1 hour	T1005			U4	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH IB1	H0045		0663		KX			11FC	18	RG418	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH IA2	H0045		0663		KX			11FC	18	RG419	1 unit = 1 hour	T1005			U2	U5			1 Unit = 15 min	

		RESPITE NF W/PEDIATRIC TRACH IA1	H0045		0663		KX			11FC	18	RG420	1 unit = 1 hour	T1005			U2	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH BB2	H0045		0663		KX			11FC	18	RG421	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH BB1	H0045		0663		KX			11FC	18	RG422	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH BA2	H0045		0663		KX			11FC	18	RG423	1 unit = 1 hour	T1005			U2	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH BA1	H0045		0663		KX			11FC	18	RG424	1 unit = 1 hour	T1005			U1	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PE2	H0045		0663		KX			11FC	18	RG425	1 unit = 1 hour	T1005			U4	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PE1	H0045		0663		KX			11FC	18	RG426	1 unit = 1 hour	T1005			U4	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PD2	H0045		0663		KX			11FC	18	RG427	1 unit = 1 hour	T1005			U4	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PD1	H0045		0663		KX			11FC	18	RG428	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PC2	H0045		0663		KX			11FC	18	RG429	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PC1	H0045		0663		KX			11FC	18	RG430	1 unit = 1 hour	T1005			U3	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PB2	H0045		0663		KX			11FC	18	RG431	1 unit = 1 hour	T1005			U2	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PB1	H0045		0663		KX			11FC	18	RG432	1 unit = 1 hour	T1005			U2	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH PA2	H0045		0663		KX			11FC	18	RG433	1 unit = 1 hour	T1005			U2	U5			1 Unit = 15 min	

		RESPITE NF W/PEDIATRIC TRACH PA1	H0045		0663		KX			11FC	18	RG434	1 unit = 1 hour	T1005			U1	U5			1 Unit = 15 min	
		RESPITE NF W/PEDIATRIC TRACH BC1	H0045		0663		KX			11FC	18	RG435	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		RESPITE NF W/PEDIATRIC TRACH PCE	H0045		0663		KX			11FC	18	RG436	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
Flexible Family Supports		FFSS - HCSS (RN/LVN) RN	S9123							11R	18	G0165	1 unit = 1 hour	H2015			99	U5			1 Unit = 15 min	
		FFSS - HCSS (RN/LVN) LVN	S9124							11R	18	G0195	1 unit = 1 hour	H2015			99	U3			1 Unit = 15 min	
		ADJUNCT - LVN	T1003		0552					11S	18	G0166	1 unit = 1 hour	H2015			99	U3			1 Unit = 15 min	
		ADJUNCT - LVN	T1003							11S	18	G0166	1 unit = 1 hour	H2015			99	U3			1 Unit = 15 min	
		ADJUNCT - RN	T1002		0552					11T	18	G0167	1 unit = 1 hour	H2015			99	U5			1 Unit = 15 min	
		ADJUNCT - RN	T1002							11T	18	G0167	1 unit = 1 hour	H2015			99	U5			1 Unit = 15 min	
		FFSS - PAS HCSS	S5120		0572					11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	
		FFSS - PAS HCSS	T1019		0572					11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	
		FFSS - PAS HCSS	T1019							11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	
		FFSS - PAS HCSS - HOMEMAKER SERVICE	S5130							11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	
		FFSS - PAS HCSS CHORE SERVICE	S5120							11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	
		FFSS - PAS HCSS COMPANION CARE-ADULT	S5135		0572					11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	

		FFSS - PAS HCSS COMPANION CARE-ADULT	S5135							11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	
		FFSS - PAS HCSS HOMEMAKER SERVICE	S5130		0572					11U	18	G0168	1 unit = 1 hour	H2015			99	U1			1 Unit = 15 min	
		FFSS - HCSS ATTENDANT DELEGATED	S5125		0572					11V	18	G0169	1 unit = 1 hour	H2015			99	U1	UA		1 Unit = 15 min	
		FFSS - HCSS ATTENDANT DELEGATED	S5125							11V	18	G0169	1 unit = 1 hour	H2015			99	U1	UA		1 Unit = 15 min	
		SPECIALIZED FFSS - HCSS RN	T1030				TG	TD	TD	11RS	18	T1032	1 unit = 1 hour	H2015			99	U5	UA		1 Unit = 15 min	
		SPECIALIZED FFSS - HCSS LVN	T1031				TG	TE	TE	11RS	18	T1033	1 unit = 1 hour	H2015			99	U3	UA		1 Unit = 15 min	
Flexible Family Supports - CDS Model		CDS SPECIALIZED FFSS - LVN	T1031							11SSV	18	G0963	1 unit = 1 hour	H2015			99	U3	UC		1 Unit = 15 min	
		CDS MDCP MONTHLY ADMINISTRATION FEE									18	G0225	1 unit = 1 month	T2040			U3				1 Unit = 1 month	
		FFSS - CDS LVN-SPECIALIZED NURSING RATE - TAXES	T1031					UG			18	G0163										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS LVN-SPECIALIZED NURSING RATE - ES/BENEFITS	T1031					UF			18	G6014										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		SPECIALIZED ADJUNCT - LVN	T1031				TG		TE	11SS	18	T1035	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS FFSS - LVN	T1003						TE	11SV	18	G0964	1 unit = 1 hour	H2015			99	U3	UC		1 Unit = 15 min	
		FFSS - CDS LVN - TAXES	T1003					UG			18	G6015										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS LVN - ES/BENEFITS	T1003					UF	TE		18	G6016										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS SPECIALIZED FFSS - RN	T1030							11TV	18	G0967	1 unit = 1 hour	H2015			99	U5	UA	UC	1 Unit = 15 min	
		FFSS - CDS RN-SPECIALIZED NURSING RATE - TAXES	T1030					UG			18	G6017										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK

		FFSS - CDS RN-SPECIALIZED NURSING RATE - ES/BENEFITS	T1030					UF			18	G6018										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		SPECIALIZED ADJUNCT - RN	T1030				TG		TD	11TS	18	T1034	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS FFSS - RN	T1002						TD	11TV	18	G0966	1 unit = 1 hour	H2015			99	U5	UC		1 Unit = 15 min	
		FFSS - CDS RN - TAXES	T1002					UG	TD		18	G6019										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS RN - ES/BENEFITS	T1002					UF	TD		18	G6020										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS - FFSS PAS HCSS	T1019		0572				UB	11UV	18	G0192	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS	T1019						UB	11UV	18	G0192	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - IND	S5135		0572				UB	11UV	18	G0192	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - IND	S5130		0572				UB	11UV	18	G0192	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - IND	S5120		0572				UB	11UV	18	G1092	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - INDIVIDUAL CHORE SERVICES	S5120						UB	11UV	18	G0192	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - INDIVIDUAL HOMEMAKER SERVICE	S5130						UB	11UV	18	G0192	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - INDIVIDUAL COMPANION CARE	S5135						UB	11UV	18	G0192	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - ADJUNCT PAS HCSS - AGENCY - CHORE SERVICES	S5120		0572				UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - ADJUNCT PAS HCSS - AGENCY - CHORE SERVICES	S5120						UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - ADJUNCT PAS HCSS - AGENCY - HOMEMAKER SERVICE	S5130						UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	

		CDS - ADJUNCT PAS HCSS - AGENCY - HOMEMAKER SERVICE	S5130		0572				UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - ADJUNCT PAS HCSS - AGENCY - COMPANION CARE	S5135						UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFFSS PAS HCSS - AGENCY	T1019		0572				UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - AGENCY - COMPANION CARE	S5135		0572				UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		CDS - FFSS PAS HCSS - AGENCY	T1019						UC	11UV	18	G0193	1 unit = 1 hour	H2015			99	U1	UA	UC	1 Unit = 15 min	
		FFSS - CDS ATTENDANT - IND - TAXES	S5120		0572			UG	UB		18	G6021										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - IND - ES/BENEFITS	S5120		0572			UF	UB		18	G6022										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - IND - TAXES	S5130		0572			UG	UB		18	G6023										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - IND - ES/BENEFITS	S5130		0572			UF	UB		18	G6024										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - IND - TAXES	S5135		0572			UG	UB		18	G6025										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - IND - ES/BENEFITS	S5135		0572			UF	UB		18	G6026										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - TAXES	T1019		0572			UG	UB		18	G6027										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - ES/BENEFITS	T1019		0572			UF	UB		18	G6028										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - INDIVIDUAL CHORE SERVICES - TAXES	S5120					UG	UB		18	G6029										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - INDIVIDUAL CHORE SERVICES - ES/BENEFITS	S5120					UF	UB		18	G6030										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK

		FFSS - CDS ATTENDANT - INDIVIDUAL HOMEMAKER SERVICES - TAXES	S5130					UG	UB		18	G6031										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - INDIVIDUAL HOMEMAKER SERVICES - ES/BENEFITS	S5130					UF	UB		18	G6032										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - INDIVIDUAL COMPANION CARE - TAXES	S5135					UG	UB		18	G6033										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - INDIVIDUAL COMPANION CARE - ES/BENEFITS	S5135					UF	UB		18	G6034										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - TAXES	T1019					UG	UB		18	G6027										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		FFSS - CDS ATTENDANT - ES/BENEFITS	T1019					UF	UB		18	G6028										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
Home Modifications		HOME MODIFICATIONS	S5165		3106					16	18	G0608	1 unit = 1 service	S5165							1 Unit = 1 service	
		HOME MODIFICATIONS	S5165							16	18	G0608	1 unit = 1 service	S5165							1 Unit = 1 service	
Day Activity Health Services		DAY ACTIVITY AND HEALTH SERVICES (TITLE XIX)	S5101							29	18	C0200	1 unit = 3-6 hours; 2 units = over 6 hours	S5101							1 unit = 3-6 hours; 2 units = over 6 hours	
Supported Employment		SUPPORTED EMPLOYMENT	H2025							37	18	H2025	1 unit = 1 hour	H2025							1 Unit = 15 min	
		CDS-SUPPORTED EMPLOYMENT-TAXES	H2025					UG	UC		18	G6067										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS-SUPPORTED EMPLOYMENT-ES/BENEFITS	H2025					UF	UC		18	G6068										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS-SUPPORTED EMPLOYMENT	H2025						UC	37V	18	H2027	1 unit = 1 hour	H2025							1 Unit = 15 min	
Transition Assistance Services		TRANSITION ASSISTANCE SERVICES (TAS)	T2038							53	18	T2038	1 unit = 1 time max benefit	T2038							1 Unit = 1 service	
		TAS FEES								53A	18	G2039	1 unit = 1 time max fee	T2038							1 Unit = 1 service	

Employment Assistance		EMPLOYMENT ASSISTANCE	H2026							54	18	H2026	1 unit = 1 hour	H2023							1 Unit = 15 min	
		CDS-EMPLOYMENT ASSISTANCE-TAXES	H2026					UG	UC		18	G6077										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS-EMPLOYMENT ASSISTANCE-ES/BENEFITS	H2026					UF	UC		18	G6078										NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
		CDS-EMPLOYMENT ASSISTANCE	H2026						UC	54V	18	H2029	1 unit = 1 hour	H2023							1 Unit = 15 min	
		CDS - MDCP ORIENTATION FEE									18	G0221	1 unit = 1 hour									NO ESTABLISHED/COMPARABLE SK SERVICE/CODE TO CROSSWALK
Adaptive Aids		DME - MISCELLANEOUS (HOSPITAL BEDS/VENTILATOR)	E0636		0290					15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME - VEHICLE MODIFICATIONS TO INCLUDE LIFT	T2028							15	18	G0500	1 unit = 1 service/item	T2039							1 Unit = 1 service	
		MEDICAL SUPPLIES - SPECIALIZED SUPPLIES (NOS)	E2510							15	18	G0500	1 unit = 1 service/item	T2028							1 Unit = 1 service	
		DME/ADP AIDS - COMMUNICATION-ELECTRONIC DEVICE	E2510							15	18	G0500	1 unit = 1 service/item	T2028							1 Unit = 1 service	
		DME/ADAPTIVE AIDS - OTHER (IN HOME/NON-VEHICLE LIFT)	T2039							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME/ADAPTIVE AIDS - OTHER (IN HOME/NON-VEHICLE LIFT)	E1130		0290					15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME/ADAPTIVE AIDS - COMMUNICATION OTHER	T2029							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME/ADAPTIVE AIDS - COMMUNICATION OTHER	E1399							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME/ADAPTIVE AIDS - COMMUNICATION DEVICE	E1902							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME/ADAPTIVE AIDS - COMMUNICATION DEVICE	E1130							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME/ADAPTIVE AIDS	E1031							15	18	G0500	1 unit = 1 service/item	T2028							1 Unit = 1 service	

		DME - VEHICLE MODIFICATIONS TO INCLUDE LIFT	E1031		0290					15	18	G0500	1 unit = 1 service/item	T2039							1 Unit = 1 service	
		DME - MISCELLANEOUS (HOSPITAL BEDS/VENTILATOR)	E0636							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME - ROLLABOUT CHAIR	T2029		0290					15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME - STANDARD WHEELCHAIR	T2028							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME - STANDARD WHEELCHAIR	T2039							15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
		DME - ROLLABOUT CHAIR	E1399		0290					15	18	G0500	1 unit = 1 service/item	T2029							1 Unit = 1 service	
Community First Choice																						
Emergency Response Monitoring Services		Emgerency Response Monthly Monitoring	S5161									G0100	1 unit = 1 month	S5161			U3	U3			1 Unit = 1 service	Source: STAR+PLUS Uniform Billing Matrix; STAR Kids Uniform Billing Matrix; DADS LTCBillCodeCrosswalk .pdf
Emergency Response Monitoring Installation		Installation of ERS equipment	S5160									G0100	1 unit = 1 service	S5160							1 Unit = 1 service	Source: STAR+PLUS Uniform Billing Matrix;
Support Management		Training offered by an FMSA to assist members and their caregiver team in becoming better employers and managers of providers working in their home.																				
Nursing Task Delegated Oversight		Skilled services by a registered nurse (rn) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an rn to ensure that essential non-skilled care achieves its purpose in the home health	G0162										1 unit = 15 min	G0162 AND T1000 U1							1 unit = 15 min	Source: STAR+PLUS Uniform Billing Matrix; STAR Kids Uniform Billing Matrix; DADS LTCBillCodeCrosswalk .pdf

APPENDIX IV MDCP FREQUENTLY ASKED QUESTIONS INFORMATION SHEET, NOVEMBER 2016

MDCP Frequently Asked Questions
Information Sheet November 2016

FAMILIES
MANAGED CARE

Q: What is managed care?

A: Managed care means you get Medicaid services through a select group of doctors, hospitals, and other health care providers --called a provider network -- through a health plan you pick.

Q: What is a health plan (also called a managed care organization or MCO)?

A: A health plan is an insurer that is licensed or approved by the Texas Department of Insurance and has a contract with the Texas Health and Human Services Commission to deliver Medicaid-covered services to its members.

Q: What is a provider network?

A: All the providers who agree to deliver services to a health plan's members.

Q: Who is a health plan member?

A: Someone getting Medicaid-covered services who has picked and enrolled with a health plan.

Q: How do I pick a health plan?

A: You will get an enrollment packet in the mail that includes information about the health plans in your area and the providers in the health plans' provider networks.

Q: What is a service area?

A: The service area includes the counties where the Medicaid health plan operates. There are 13 Medicaid managed care areas in the state. You can see which service area you are in here.

Everyone in managed care has at least two health plans in their service area. The service area you are in is based on the most current address on record with Medicaid or the Social Security Administration.

Please make sure your addresses are up to date.

Q: How do I update my Medicaid or Medicare addresses?

For Medicaid, make changes to your address and phone number by going to the Your Texas Benefits website. You can also make changes by phone.

Phone: Call 211 and select English or Spanish

Web: Go to www.YourTexasBenefits.com and follow these steps:

- Log in to your account
- Go to the "View my case" section of the website
- Click on the "Case facts" tab near the top of the page
- Find the case number for the record you need to change. Click on "Report a change" button next to that case number

After you do this, you will be shown a "Getting started" page that will walk you through the rest of the process.

If you get Social Security benefits or are enrolled in Medicare, you can change your address online by using a my Social Security account. Go to: my Social Security - Sign in or Create an Account.

If you get Supplemental Security Income (SSI), don't have a U.S. mailing address, or can't change your address online, call us at 1-800-772-1213 (TTY 1-800-325-0778), 7 a.m. to 7 p.m., Monday through Friday or contact your local Social Security office.

Q: What are the goals of managed care?

A: Managed care is designed to improve healthcare by improving access to care and coordination of care. This will help make sure you are getting the right services, have a primary care provider and a medical home.

Q: Why are we changing to managed care?

A: Lawmakers directed HHSC to create STAR Kids in 2013. The program serves children and young adults 20 and younger with disabilities. Senate Bill 7 requires STAR Kids health plans to provide Medically Dependent Children Program (MDCP) waiver services. HHSC is working closely with the STAR Kids Managed Care Advisory Committee and the Children's Policy Council to start this program.

Medical Home and Primary Care Provider (PCP)

Q: What is a medical home?

A: A medical home is where you get your basic care. It includes your primary care provider. It helps build the relationships between the patient and family with the doctor and other care providers.

Q: What is a Primary Care Provider (PCP)?

A: When you join STAR Kids, you will pick a primary care provider. This is a doctor, nurse, or clinic where you will get basic medical care and get referrals for other care. Primary care providers are a medical home to members. They get to know you and your health history. Your primary care provider can be one of the following:

- General practice doctor
- Family practice doctor
- Internal medicine doctor
- Pediatric doctor
- Obstetrics/Gynecology doctor
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA)
- Clinic (Federally Qualified Health Center or Rural Health Clinic)
- Specialist physicians willing to provide a health home to selected members with special needs or conditions

If you have Medicare, you won't need to pick a primary care provider.

Q: What if I don't pick a Primary Care Provider (PCP)?

A: If you don't pick a primary care provider, one will be assigned for you. You can always change primary care providers by calling your health plan.

Q: Can I change my primary care provider (PCP)?

A: Yes. Call your health plan to change your primary care provider.

Q: Can my primary care provider be a specialist?

A: Yes, as long as your specialist is willing to act as your primary care provider. If this is something you want, talk to your specialist and your health plan. Primary care providers must work with your caregivers and other providers to make sure your Medicaid medical and behavioral health care needs are met.

Q: What if I need to see a specialist or go to the hospital?

A: Your primary care provider will help you with basic medical care. If you need other medical services, your primary care provider will give you a referral. For example, if you need to see a specialist or go to the hospital, your primary care provider will set that up for you. The health plans can choose what services need referrals. Check with the health plans in your area to find out about their referral process.

You don't need a referral from your primary care provider for some services, like:

- Mental health and drug and alcohol abuse treatment
- Texas Health Steps checkups
- Emergency room services

Some plans may not require referrals for certain services.

STAR Kids

Q: What is STAR Kids?

A: STAR Kids is a new Texas Medicaid managed care program for children and adults 20 or younger who have disabilities. Under STAR Kids, you will get basic medical and long-term services and supports through the health plan's provider network. Long-term services and supports include things like help in your home with basic daily activities, and help participating in community activities, if you are eligible. You also will get Medically Dependent Children Program (MDCP) waiver services through the health plan's provider network, if you are eligible.

Q: When will STAR Kids start?

A: STAR Kids will begin statewide November 1, 2016.

Q: Do I have to join STAR Kids?

A: You must join STAR Kids if you are 20 or younger, covered by Medicaid, and meet one or more of the following conditions:

- Get Supplemental Security Income (SSI)
- Get SSI and Medicare
- Get services through the Medically Dependent Children Program (MDCP) waiver
- Get services through the Youth Empowerment Services (YES) waiver
- Live in a community-based intermediate care facility for individuals with an intellectual disabilities or related condition (ICF-IID) or in a nursing facility
- Get services through a Medicaid Buy-In program
- Get services through any of the following Department of Aging and Disability Services (DADS) intellectual and developmental disability (IDD) waiver programs:
    - Community Living Assistance and Support Services (CLASS)
    - Deaf Blind with Multiple Disabilities (DBMD)

- Home and Community-based Services (HCS)
- Texas Home Living (TxHmL)

Q: Who is not in STAR Kids?

A: You can't be in STAR Kids if you:

- Are in foster care and get Medicaid services through traditional Medicaid or STAR Health
- Are 21 or older
- Live in the Truman W. Smith Children's Care Center
- Live in a state veteran's home
- Live in a State Supported Living Center (SSLC)

STAR Kids Services

Q: What services does STAR Kids offer?

A: Everyone will get:

- **A care plan.** This will help your doctors and other providers know what kind of care you need. A service coordinator who works for the STAR Kids health plan will work with you and your doctor create this plan. The service coordinator will also help you find doctors, make appointments, and help with other needs you might have.
- **A primary care provider.** You will get most of your preventive healthcare through this provider. Your primary care provider can also refer you to specialists, if needed.
  - If you get Medicare, you won't choose a primary care provider.
- **Basic health care services.** You will get Medicaid services like you get now, such as doctor's visits, hospital visits, therapies, specialist visits, medical equipment, prescription drugs, and medical supplies.
- **Long-Term Services and Support (LTSS).** You will get long-term services and supports in the home, like Personal Care Services, Community First Choice, or Private Duty Nursing. Long-term services and supports include things that help you in your home with basic daily activities, and help you participate in community activities.
  - If you get services through a Department of Aging and Disability Services (DADS) intellectual and developmental disability (IDD) waiver, the Youth Empowerment Services (YES) waiver, or live in an Intermediate Care Facility (ICF-IID), you will get your long-term services and supports through your waiver or facility, the way you do today.
  - If you get services through Medically Dependent Children Program (MDCP) waiver, you will get those services through the STAR Kids health plan you pick.
  - To learn more about the Community First Choice, visit the HHSC CFC webpage. The page gives general information about the benefit and isn't specific to STAR Kids.
- **Service Coordination.** Health plan nurses and other professionals will be your service coordinators. Their services include things like:
  - Identifying physical health, mental health, and long-term services and supports needs

    - Creating service plans to address identified needs
    - Finding doctors who will take Medicaid
    - Getting access to other services and providers
- **Value-added services.** These are the extra services offered by the STAR Kids health plan you pick, like respite or extra vision services.

Q: What will happen to my current authorizations and services when I change to STAR Kids? Will my authorizations be honored, and will I continue to get services?

A: Yes. To ensure ongoing care, STAR Kids health plans must honor existing authorizations for:

- Long-term services and supports, like Personal Care Services, Community First Choice, or Private Duty Nursing, for 6 months, or until the health plan does a new assessment.
- Acute services, like doctor visits, hospital visits, and labs, are honored for 90 days, until the end of the current authorization, or until the health plan does a new assessment.

Q: Will my Medicaid dental services change?

A: There will be no change to dental services. You will continue to get dental services as you do today.

Picking a Health Plan

Q: How do I pick a STAR Kids health plan?

A: Families will start getting information about STAR Kids in the mail this summer, including information on how to pick a health plan.

- Families will get an introduction letter in **July 2016**. This letter will have basic information about STAR Kids.
- Families will get a STAR Kids enrollment packet in **August 2016**. The enrollment packet will have:
    - Provider directories that list the doctors and other providers for each health plans in your service area.
    - Instructions about how to pick a health plan, and other helpful information.
    - A phone number to call to get help or ask questions about picking a health plan.
- Starting **August 1, 2016**, you can call MAXIMUS, the State's enrollment broker, to ask questions.
    - The MAXIMUS toll-free number will be in your enrollment packet.
    - A link to the MAXIMUS toll-free number will also be on the STAR Kids website on August 1, 2016.
- Once you get the enrollment packet in August, you can call MAXIMUS to pick a plan over the phone, or you can mail your enrollment information using the postage-paid envelope.
- Families who don't pick a health plan will get a reminder letter in **September**

2016.

- If you haven't picked a health plan by **October 12, 2016**, HHSC will pick one for you.
- STAR Kids starts **November 1, 2016**.

Q: Who do I contact if I have questions or need help picking a STAR Kids health plan?

A: You can contact MAXIMUS, the State's enrollment broker, for help picking a STAR Kids health plan. You can also directly contact the STAR Kids health plans in your area. Your STAR Kids enrollment packet, which will be mailed in August, will have contact information for MAXIMUS, and the health plans in your area.

Starting August 1, 2016, you can call MAXIMUS, the State's enrollment broker, to ask questions. Once MAXIMUS and the health plans are ready to take calls, their information will be listed below. MAXIMUS and STAR Kids health plan contact information also will be included in the enrollment packet you get in August.

Q: What are value-added services?

A: Value-added services, approved by HHSC, are extra health services offered by the health plans in addition to regular Medicaid services.

Q: How will I know if my doctors and other providers are contracted with a STAR Kids health plan?

A: When you get your enrollment packet in August, check the enclosed provider directories for the providers you see today. If one of your doctors isn't listed, you can call the health plan to see if they are contracted with them. You can also talk to your doctor about reaching out to the health plans to try to contract.

Q: What if my doctor isn't enrolled with the STAR Kids health plans in my service area?

A: You can make a list of all the providers your child sees, and contact them to encourage them to enroll with the STAR Kids health plans in your service area. You can also share your provider list with the STAR Kids health plans in your service area and ask them to contract with your providers if they haven't done so already. You can do this today.

When you get your enrollment packet in August, check the enclosed provider directory for the providers you see today. If one of your doctors isn't listed, you can look up the health plan or call the health plan to see if they are contracted with them. You can also talk to your doctor about signing up for the health plan. STAR Kids health plans must try to contract with all Medicaid providers who see children going into STAR Kids today. Providers don't have to contract with a health plan if they don't want to. Health plans and providers can do single-case agreements in some situations if a provider only wants to see you, but not everyone else in STAR Kids.

Q: Can I change health plans?

A: Yes, you can change health plans any time by contacting MAXIMUS, the State's enrollment broker. It can take 30 to 45 days for the change to go into effect. Once MAXIMUS and the health plans are ready to accept calls, their information will be listed below. MAXIMUS and STAR Kids health plan contact information also will be in the enrollment packet you get in August.

Other Insurance, Including Medicare

Q: What if I have private health insurance?

A: If you have private health insurance, your private insurance will pay first, then the health plan will pay the rest of any service covered by Medicaid.

Q: What if my primary care provider (PCP) is under my private insurance and isn't a Medicaid provider?

A: The law requires that orders, referrals, and prescriptions for Medicaid services come from a Medicaid enrolled provider. If your private primary care provider will be ordering, referring, or prescribing Medicaid services, your doctor must complete a shortened application to continue ordering, referring, or prescribing services or medicines that will be reimbursed by Medicaid.

HHSC is working with private providers around the state to try to get them to enroll in Medicaid, but it is important for you to talk to your providers, too. Tell them how important it is to enroll with Medicaid so they can continue your care. There are no fees to complete the shortened ordering, referring, and prescribing process, and they can sign up electronically or on paper. If your private provider is ordering, referring, or prescribing Medicaid services, they should visit the following links:

- Information for Ordering and Referring-Only providers
- Enroll Online: https://secure.tmhp.com/ProviderEnrollment
- Paper Application

After you have picked a health plan, your STAR Kids service coordinator can help coordinate between private providers and Medicaid providers

Q: What if I have Medicare?

A: If you have Medicare and Medicaid, you are known as a "dual eligible," and will keep getting most of your basic health-care services through your Medicare doctors. STAR Kids will not change the way you get Medicare services.

Medicare will pay for most of your basic healthcare services, and traditional Medicaid will pay for services that are covered by Medicaid but aren't covered by Medicare. If you have Medicare, you won't pick a STAR Kids primary care provider.

After you have picked a health plan, your STAR Kids service coordinator will help coordinate between Medicare providers and Medicaid providers.

Q: If my primary care provider (PCP) is under my private insurance, do I have to choose a STAR Kids primary care provider?

A: If your private primary care provider isn't contracted with the STAR Kids health plan you have chosen, you will have to pick a STAR Kids primary care provider. This means you will have two primary care providers: a private primary care provider and a STAR Kids primary care provider. After you have picked a STAR Kids health plan and primary care provider, your service coordinator will help coordinate between private providers, Medicaid providers, and Medicare providers.

Out-of-Area and Out-of-Network Providers

Q: One or more of my providers are in another service area. Can I join an STAR Kids health plan in that other service area?

A: No, you must choose a STAR Kids health plan in the service area where you live.

Q: Can I see doctors and specialists outside my service area?

A: Health plans must have an adequate network of providers and provide services members need inside their service area. Health plans can pay providers outside their service area in certain situations, such as emergency services and to maintain ongoing care with an existing provider. Sometimes you might need to go outside your service area to get the care you need. The STAR Kids health plan you select will have a process to help you if you must see providers outside your service area.

Medically Dependent Children's Program (MDCP)

Q: Will STAR Kids change how a child becomes eligible for the Medically Dependent Children Program (MDCP)?

A: STAR Kids won't change how you become eligible for MDCP. There will still be a MDCP interest list and a set number of MDCP slots. To become eligible for MDCP services, you must come to the top of the MDCP interest list and meet medical necessity and other program requirements. HHSC and your STAR Kids health plan will help you through the process when you come to the top of the MDCP interest list.

Q: What will change if my child already is in MDCP?

A: If your child is already enrolled in MDCP, you will continue to get the same MDCP services you get today through the STAR Kids health plan you pick. Under STAR Kids, the health plan will do the assessment, develop the service plan, and authorize MDCP services.

Q: Will the annual budget for MDCP still work the same way?

A: Yes. Your health plan service coordinator will help you make a service plan for MDCP services within your approved budget.

Q: Will I still have a Department of Aging and Disability Services (DADS) MDCP case manager?

A: No. When you are in STAR Kids, you will have a STAR Kids health plan service coordinator. This service coordinator will do the things your DADS case manager does today, like service planning and assessments.

Consumer Directed Services (CDS)

Q: Will the Consumer Directed Services option still be available through STAR Kids?

A: Consumer Directed Services will still be available once STAR Kids begins. If you get services from one of the waivers below and use CDS, the Consumer Directed Services will continue to be available through the Department of Aging and Disability Services (DADS).

- Deaf-Blind with Multiple Disabilities (DBMD)
- Community Living Assistance and Support Services (CLASS)
- Home and Community-based Services (HCS)
- Texas Home Living (TxHmL)

Consumer Directed Services for the Medically Dependent Children Program will be available through the STAR Kids health plan you pick instead of DADS.

If you use Consumer Directed Services for Personal Care Services or Community First Choice, and aren't getting services through the programs listed above, the CDS will be available through the STAR Kids health plan you pick.

APPENDIX V STAR HEALTH

Reserved

APPENDIX VI TRANSITION ACTIVITIES

1360 **Transition Activities:**

The managed care organization (MCO) must conduct the following transition timeline activities with the member or legally authorized representative.

Transition Activities at age 15-16

Transition topics must include, but are not limited to:

- Member's knowledge of his/her health care needs, including disease process and progression specific to members' active diagnoses.
- Health and wellness education to assist the member with self-management.
- Alternative caregiver identified and a written back-up plan is in place in the event the primary caregiver is unable to care for member.
- Promote independence and social skills by discussing available programs such as camps.
- If there is a Transition Plan (School) in place for members with an Individualized Education Program (IEP). If no transition plan is in place, inform member to reach out to the school to have a transition plan developed. If desired by the member or the member's legally authorized representative (LAR), coordination with the member's school and IEP to ensure consistency of goals, include any 504 plans, if applicable.
- What age member will no longer receive educational services and begin career planning, such as:
    - Coordination with Texas Workforce Commission to help identify future employment and employment training opportunities;
    - Explore opportunities for higher education, such as college or technical school.
- Provide information and referrals to community organizations that are important to the health and wellbeing of members. These organizations include but are not limited to:
    - State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health, intellectual or developmental disabilities, rehabilitation, income support, nutritional assistance, family support agencies, etc.) For members with progressive vision loss, a referral is made to explore services offered through Texas School for the Blind and Visually Impaired;
    - Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);
    - City and county agencies (e.g., welfare departments, housing programs, etc.);
    - Civic and religious organizations; and
    - Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.)
- Children's services that are no longer available to adults, such as private duty nursing (PDN) and Medically Dependent Children Program (MDCP). For individuals receiving PDN, STAR+PLUS Home and Community Based Services (HCBS) Program or an Intellectual Developmental Disability (IDD) waiver will need to cover medically necessary nursing services that are not intermittent or part-time at age 21, which may not be the same level of nursing they receive through STAR Kids. To be eligible for STAR+PLUS

HCBS Program or an IDD waiver, the individual's health and safety must be ensured under the cost limit for the waiver program.
- Discuss guardianship at least annually

Transition Activities at age 17

- Goals and ways for the member to begin managing their own medical care such as the member's making and keeping their own medical appointments, ordering their own supplies, etc.
- Alternative caregiver identified and a written back-up plan is in place in the event the primary caregiver is unable to care for member.
- Discuss transportation options.
- Assist the member with looking for a Primary Care Physician (PCP), specialists as necessary, and a dentist.
- Discuss current and possible future community living options. Coordinate visits with potential providers or facilities, if applicable
- Services available through STAR Kids at age 18, such as Day Activity Health Services (DAHS)
- Children's services that are no longer available to adults, such as private duty nursing (PDN) and Medically Dependent Children Program (MDCP). For individuals receiving PDN, STAR+PLUS Home and Community Based Services (HCBS) Program or an Intellectual Developmental Disability (IDD) waiver will need to cover medically necessary nursing services that are not intermittent or part-time at age 21, which may not be the same level of nursing they receive through STAR Kids. To be eligible for STAR+PLUS HCBS Program or an IDD waiver, the individual's health and safety must be ensured under the cost limit for the waiver program.
- Provide information and referrals to community organizations that are important to the health and wellbeing of members. These organizations include but are not limited to:
    - State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health, intellectual or developmental disabilities, rehabilitation, income support, nutritional assistance, family support agencies, etc.) For members with progressive vision loss, a referral is made to explore services offered through Texas School for the Blind and Visually Impaired;
    - Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);
    - City and county agencies (e.g., welfare departments, housing programs, etc.);
    - Civic and religious organizations; and
    - Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.)
- Discuss guardianship and provide contact information

Transition Activities at age 18-19

- **Verify eligibility for Supplemental Security Income (SSI) the month of member's 18th birthday**
- Assist the member with looking for a Primary Care Physician (PCP), specialists as necessary, and a dentist.

- Children's services that are no longer available to adults, such as private duty nursing (PDN) and Medically Dependent Children Program (MDCP). For individuals receiving PDN, STAR+PLUS Home and Community Based Services (HCBS) Program or an Intellectual Developmental Disability (IDD) waiver will need to cover medically-necessary nursing services that are not intermittent or part-time at age 21, which may not be the same level of nursing they receive through STAR Kids. To be eligible for STAR+PLUS HCBS Program or an IDD waiver, the individual's health and safety must be ensured under the cost limit for the waiver program.
- Provide information and referrals to community organizations that are important to the health and wellbeing of members. These organizations include but are not limited to:
    - State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health, intellectual or developmental disabilities, rehabilitation, income support, nutritional assistance, family support agencies, etc.) For members with progressive vision loss, a referral is made to explore services offered through Texas School for the Blind and Visually Impaired;
    - Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);
    - City and county agencies (e.g., welfare departments, housing programs, etc.);
    - Civic and religious organizations; and
    - Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.)
- Discuss current and possible future community living options. Coordinate visits with potential providers or facilities, if applicable
- Assess member's needs for adaptive aids, new equipment due to growth and development, and minor home modifications, as necessary.
- Discuss guardianship and provide contact information

Transition Activities at age 20.

- STAR Kids eligibility, Medically Dependent Children Program (MDCP) or private duty nursing services terminate on the last day of the month in which their 21st birthday occurs.
- STAR+PLUS Home and Community Based Services (HCBS) Program may be an option available to the individual at age 21. The managed care organization (MCO) must also present an overview of the array of services available in STAR+PLUS HCBS Program.
- Children's services that are no longer available to adults, such as private duty nursing (PDN) and MDCP. For individuals receiving PDN, STAR+PLUS HCBS or an Intellectual Developmental Disability (IDD) waiver will need to cover medically necessary nursing services that are not intermittent or part-time at age 21, which may not be the same level of nursing they receive through STAR Kids. To be eligible for STAR+PLUS HCBS Program or the IDD waiver, the individual's health and safety must be ensured under the cost limit for the waiver program.
- Assist the member with looking for an adult Primary Care Physician (PCP), specialists as necessary, and a dentist.
- Provide information and referrals to community organizations that are important to the health and wellbeing of members. These organizations include but are not limited to:
    - State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health, intellectual or developmental disabilities,

rehabilitation, income support, nutritional assistance, family support agencies, etc.) For members with progressive vision loss, a referral is made to explore services offered through Texas School for the Blind and Visually Impaired;
    - Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);
    - City and county agencies (e.g., welfare departments, housing programs, etc.);
    - Civic and religious organizations; and
    - Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.)
- Discuss current and possible future community living options. Coordinate visits with potential providers or facilities, if applicable
- Assess member's needs for adaptive aids, new equipment due to growth and development, and minor home modifications, as necessary.
- Discuss guardianship and provide contact information
- STAR+PLUS HCBS Program enrollment process will begin no later than nine months prior to their 21st birthday
- The Program Support Unit (PSU) will send STAR+PLUS HCBS Program enrollment packets (containing the STAR+PLUS MCO list and a comparison chart) to the individual nine months prior to their 21st birthday.
- The importance of choosing an MCO six months before the 21st birthday in order to avoid being assigned an MCO or having a gap in services.
- The member/available supports can change MCOs any time after the first month of enrollment.
- STAR+PLUS HCBS Program has a cost limit based on a medical assessment, the Medical Necessity/Level of Care (MN/LOC) Assessment. The limit is 202 percent of the member's Resource Utilization Group (RUG).The assessment results in the cost limit for the annual individual service plan (ISP).
- To be eligible for STAR+PLUS HCBS Program, an ISP must be developed within the cost limit that will meet the individual's needs and ensure health and safety.
- If an ISP cannot be developed within the cost limit that ensures the health and safety, STAR+PLUS HCBS Program will be denied.
- The ISP considers all resources available to meet the member's needs, including community supports, other programs, and what the member's informal support system can provide to meet the member's needs.
- The STAR+PLUS HCBS Program assessment process will begin six months before the individual's 21st birthday. The PSU will contact the member to begin the assessment process and find out which STAR+PLUS MCO has been selected. If an MCO has not been selected, then 30 days is allowed for a selection. After 30 days, an MCO is selected for the individual.
- After the STAR+PLUS MCO is selected, the MCO will contact the individual to begin the assessment for services and assist the member/available supports in identifying and developing additional resources and community supports to help meet the individual's needs.

CDS Training for Service Coordinators

Training Objectives

- To make you – the Service Coordinator – more comfortable explaining CDS to our members.

Contents:

What is CDS – Consumer Directed Services?

CDS is not a program. CDS is a service delivery option which allows persons who are older or those with disabilities who are receiving long term care services and supports through the Texas Medicaid Program to become the employers for their own service providers.

The member or their legally authorized representative (LAR) is responsible for recruiting, hiring, training, managing and, when necessary, firing their employees. They utilize an agency to provide them with the support they need to be an employer. This agency is called a financial management services agency – FMSA.

WHAT DOES THE CDS SERVICE DELIVERY OPTION MEAN?

For the services the member or their LAR chooses to self-direct, the member or their LAR hires and manages the service provider rather than having a home care agency conduct the hiring and management activities. The services not chosen to self-direct remain with the home care agency.

The member or their LAR selects a financial management services agency (FMSA) to assist with the service delivery option including conducting payroll functions on behalf of the CDS employer (the member), assisting with budgeting, human resource functions, and monitoring hours.

Services That Can Be Self-Directed in STAR Kids

- Community First Choice (CFC) Attendant services
- CFC habilitation services
- Personal Care Services
- Medically Dependent Children Program (MDCP) Respite
- MDCP Flexible Family Support Services
- MDCP Supported Employment
- MDCP Employment Assistance

WHY DO MEMBERS CHOOSE CDS?

Members and their LARs choose CDS for a variety of reasons. Most want more control over how and when their care is delivered.

- **Self -Determination**
- **Empowerment**
- **Independence**

The Philosophy behind Consumer Direction

Consumer direction is grounded in the philosophy of self-determination. Self-determination allows individuals to: exercise greater control over their own lives; develop and reach goals they have set for themselves; and take part more fully in the world around them.

> ***self-de·ter·mi·na·tion (s lf d -tûr m -n sh n); noun***
>
> ***1. Determination of one's own fate or course of action without compulsion; free will.***

5 Principles of Self-Determination

1) **Freedom** to exercise the same rights as all citizens, and with assistance when necessary, to establish where they want to live, with whom they want to live and how their time will be occupied
2) **Authority** over a targeted amount of dollars
3) **Support** to organize resources in ways that are life enhancing and meaningful to the individual
4) **Responsibility** for the wise use of public dollars and recognition of the contribution individuals with disabilities can make to society
5) **Confirmation** of the important leadership role that individuals with disabilities and their families must play and support for the self-advocacy movement

The CDS option moves toward a self-determination system by allowing individuals to have:

- Increased control over services and supports
- Increased control over the persons that provide services and supports
- Informed-choice for decision making
- Understanding of the risks and benefits of decisions

What about our members?

More and more members are defining themselves by their “abilities” rather than their “dis”abilities. They want to be a part of the community and they are reaching out for activities that will accommodate them. CDS is a service delivery option that helps them reach their goals.

Glossary of Terms:

- **CDS (Consumer Directed Services)**: the member or his legally authorized representative or guardian is the employer of and retains control over the hiring, management, and termination of an individual providing certain services.
- **Service Coordinator:** the person with primary responsibility for providing service coordination and care management to STAR+PLUS members.
- **Legally Authorized Representative (LAR):** the member’s representative defined by state or federal law, including Tex. Occ. Code § 151.002(6), Tex. Health & Safety Code § 166.164, and Tex. Estates Code Ch. 752.
- **Designated Representative (DR):** A willing adult appointed by the CDS employer to assist with or perform the employer's required responsibilities to the extent approved by the employer. A DR, usually a family member, is not a paid service provider and is at least 18 years of age.

- **CDS Employer:** an individual (or LAR, parent, or court appointed guardian) who chooses to participate in the CDS option and therefore is responsible for hiring and retaining service providers to deliver program services.
- **Employee (a.k.a. service provider):** An individual who is hired, trained, and managed by the employer to provide services authorized by the MCO.
- **Financial Management Services Agency (FMSA):** An agency contracting with the MCO that provides financial management services for an employer who participates in the Consumer Directed Services (CDS) option.
- **Managed care organization (MCO):** An insurer licensed by the Texas Department of Insurance that coordinates health care for Medicaid members in exchange for a monthly premium
- **Service Plan:** A plan of care developed by the MCO Service Coordinator authorizing tasks to be performed by the service provider (e.g. Individual Service Plan (ISP).

Explaining CDS to our Members

Some specific reasons members select the CDS delivery option are:

1) They can target job advertisements for specific needs.
2) They can hire nontraditional employees, such as friends and church members who may not otherwise apply for work in the general field of attendant care.
3) They can adjust pay rates or award bonuses based on employee performance and/or tenure.
4) They can schedule flexible hours of service to fit the member's lifestyle.

Forms 1581, 1582, 1583, 1584, 1585, and 1586

The Department of Aging and Disability Services (DADS) developed a series of forms that will help you explain and offer the CDS option to our members. They contain all of the basic information necessary for members to make an informed decision as to whether or not CDS is right for them. **All forms in their entirety are in Appendix A.**

Form 1581- Consumer Directed Services (CDS) Option Overview

Purpose: To provide an overview of the benefits and responsibilities of the Consumer Directed Services (CDS) option.

<u>The Service Coordinator presents the overview to all initial applicants, individuals receiving ongoing services at scheduled annual reassessments, and individuals who request information on the CDS option. The Service Coordinator informs the individual of the right to choose service delivery through the Agency option or the CDS option.</u>

TEXAS Department of Aging and Disability Services

Form 1581
June 2015-E

Consumer Directed Services (CDS) Option Overview

This information will help you decide if you want to participate in the **CDS** option for services available for delivery through CDS in your program.

If you or your legally authorized representative (LAR) chooses the CDS option, one of you must be the employer of your service providers for those services chosen to be delivered through CDS.

- The employer (individual or LAR) may appoint an adult as the designated representative (DR) to assist or to perform employer responsibilities in the CDS option. If the employer is not able to complete a self-assessment for CDS, a DR must be appointed.
- You may be eligible for Support Consultation Services to provide additional assistance and training for employer responsibilities in CDS.
- The employer or DR must:
  - select a CDS agency to administer fiscal management services, provide orientation services to the employer and to act as the employer's agent with governmental agencies.
  - hire, fire, train and manage your service providers. Service providers include employees, contractors and vendors. Some services may require that backup service providers be available to deliver services when the regular provider is not available.
  - control how your allocated program funds for each service are spent on wages and benefits for your employee(s) and pay for services delivered by contractors and vendors.

Form 1581 – What do you need to understand about this form?

First, the member needs to understand who will be the employer. You will help with this. The employer can be:

- An INDIVIDUAL receiving services - who is at least 18 years of age and does NOT have a court- appointed guardian; or
- The PARENT or LEGALLY AUTHORIZED REPRESENTATIVE (LAR) of a minor-aged individual; or
- The COURT- APPOINTED GUARDIAN – regardless of the age of the individual receiving services.

The CDS employer (member or LAR) may appoint an adult as the designated representative (DR) to assist or to perform employer responsibilities in the CDS option. **If the employer is not able to complete a self- assessment (Form 1582) for CDS, a DR must be appointed.**

The employer or the DR is responsible for:

- Selecting an FMSA from a choice list provided by the Service Coordinator.
- Hiring, firing, training and managing their service providers. Service providers include employees, contractors and vendors.

Form 1581 – Page Two

The second page of the form is a comparison between the CDS option and the traditional homecare agency option. It shows some of the differences in responsibilities between the two. This is where the term FMSA is introduced – it means Financial Management Services Agency.

Differences in CDS and Agency Service Delivery Options

Questions Regarding Payment Options	CDS Option	Agency Option
Who is the employer?	Individual receiving services or the individual's LAR	Provider agency
Who is responsible for recruiting, hiring, managing and firing employees and retaining contractors and vendors? Who is responsible for backup services?	Employer and, when applicable, the DR	Provider agency
Who determines the rate of pay and benefits, such as bonuses, for employees?	Employer or DR with assistance and verification by the FMSA	Provider agency
Who is responsible for paying taxes and payroll?	FMSA, the employer-agent	Provider agency
Who must ensure documented criminal history checks are completed and verify each service provider is eligible to provide specific services?	Employer/DR (with assistance and verification by the FMSA)	Provider agency

There is a reference to criminal history checks. New rules require the employer to have the FMSA do all background checks. The employer and the prospective employee fill out a request to have the background checks completed.

Who is responsible for paying taxes and payroll?	FMSA, the employer-agent	Provider agency
Who must ensure documented criminal history checks are completed and verify each service provider is eligible to provide specific services?	Employer/DR (with assistance and verification by the FMSA)	Provider agency
Who is responsible for on-the-job injury and other liabilities of service providers?	Employer	Provider agency

This form also states that the employer is responsible for monitoring employment-related costs.

Who is responsible for monitoring program service delivery?	Employer/DR and case manager	Individual or LAR, provider agency and case manager
Who is responsible for monitoring employment-related costs?	Employer/DR and FMSA	provider agency

This means the employer is responsible for:

- Working with the FMSA to develop a budget to cover all expenses.
- Sticking to the hours authorized on the service plan.
- Not paying employees more than allocated in the budget.

The FMSA is responsible for recording all of these expenses and giving the employer and Service Coordinator a quarterly report.

The member and/or the LAR sign at the bottom. By obtaining the employer signature, you are acknowledging that a verbal overview was provided and the employer understands the requirements.

Who is responsible for monitoring employment-related costs?	Employer/DR and FMSA	provider agency

Acknowledgement and Receipt of Form 1581

Signature - Individual/LAR

Date

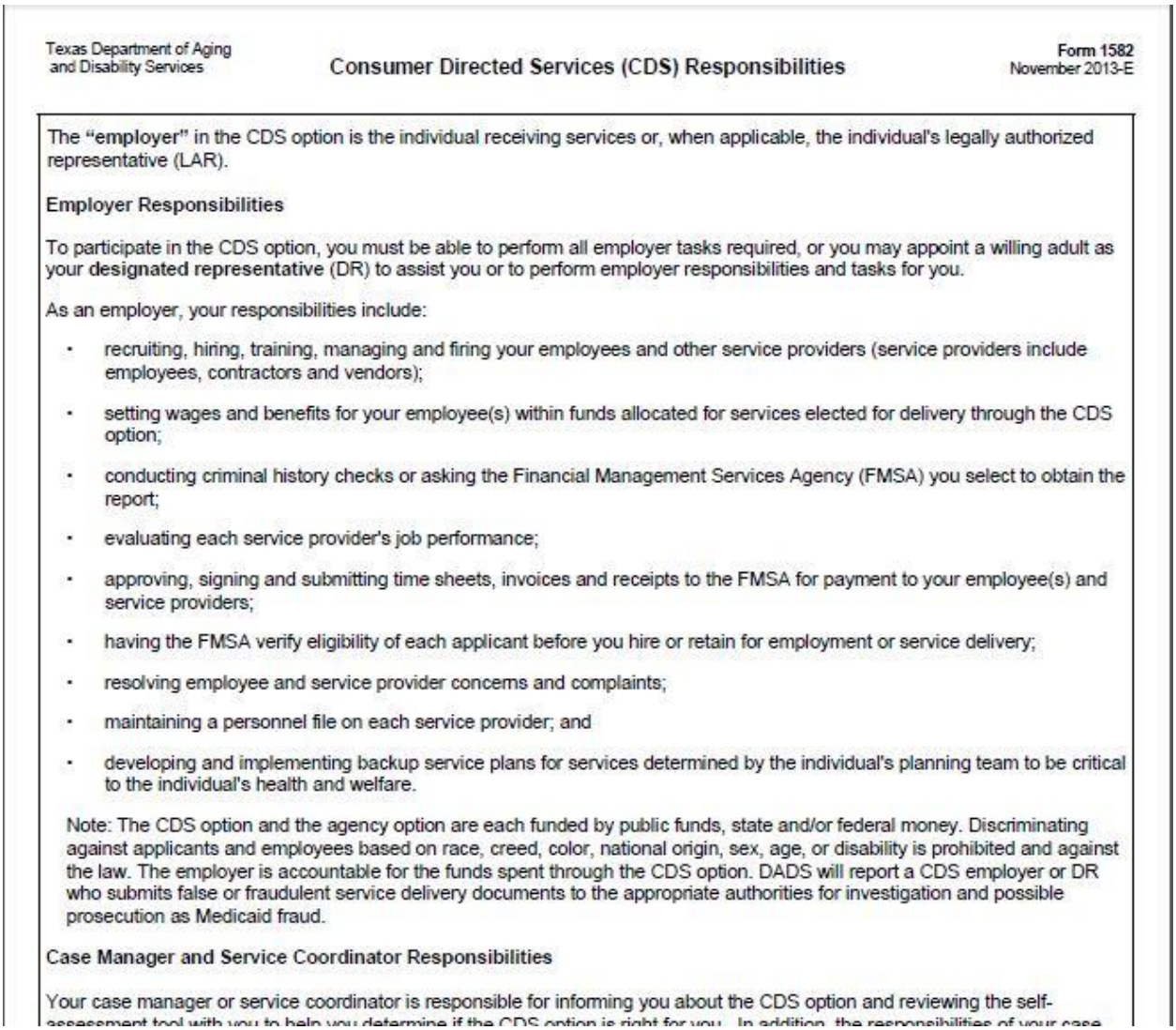
Relationship of LAR to the Individual Receiving Services

Signature - Case Manager/Service Coordinator

Date

Form 1582 – Consumer Directed Services (CDS) Responsibilities

Purpose: To build on the overview provided in Form 1581 and present a more detailed picture of the employer's responsibilities in consumer direction.



Texas Department of Aging and Disability Services

Consumer Directed Services (CDS) Responsibilities

Form 1582
November 2013-E

The **"employer"** in the CDS option is the individual receiving services or, when applicable, the individual's legally authorized representative (LAR).

Employer Responsibilities

To participate in the CDS option, you must be able to perform all employer tasks required, or you may appoint a willing adult as your **designated representative** (DR) to assist you or to perform employer responsibilities and tasks for you.

As an employer, your responsibilities include:

- recruiting, hiring, training, managing and firing your employees and other service providers (service providers include employees, contractors and vendors);
- setting wages and benefits for your employee(s) within funds allocated for services elected for delivery through the CDS option;
- conducting criminal history checks or asking the Financial Management Services Agency (FMSA) you select to obtain the report;
- evaluating each service provider's job performance;
- approving, signing and submitting time sheets, invoices and receipts to the FMSA for payment to your employee(s) and service providers;
- having the FMSA verify eligibility of each applicant before you hire or retain for employment or service delivery;
- resolving employee and service provider concerns and complaints;
- maintaining a personnel file on each service provider; and
- developing and implementing backup service plans for services determined by the individual's planning team to be critical to the individual's health and welfare.

Note: The CDS option and the agency option are each funded by public funds, state and/or federal money. Discriminating against applicants and employees based on race, creed, color, national origin, sex, age, or disability is prohibited and against the law. The employer is accountable for the funds spent through the CDS option. DADS will report a CDS employer or DR who submits false or fraudulent service delivery documents to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

Case Manager and Service Coordinator Responsibilities

Your case manager or service coordinator is responsible for informing you about the CDS option and reviewing the self-assessment tool with you to help you determine if the CDS option is right for you. In addition, the responsibilities of your case

Form 1582 – What do you need to understand about this form?

If you reviewed the Form 1581 with your member and he or she has expressed an interest in learning more, the Form 1582 gives you the basis for providing that additional information, while also allowing you, the Service Coordinator, to explore family and community support that may be available to assist the member.

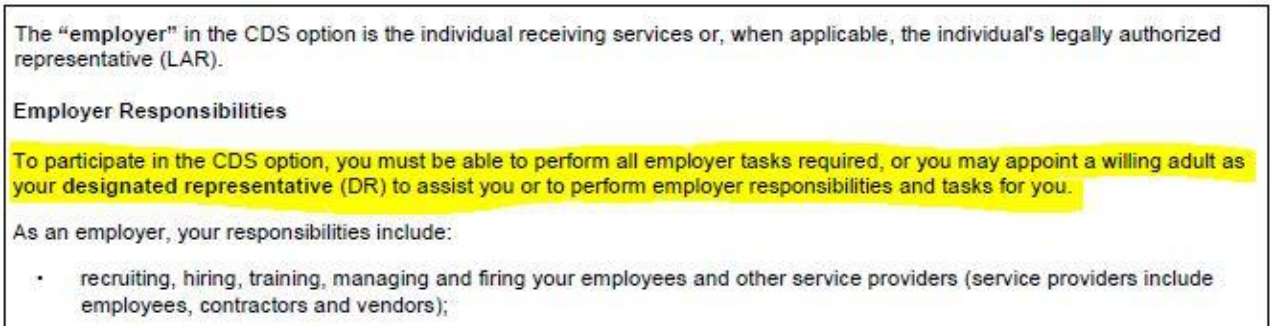
Form 1582 – Page 1 – Employer Responsibilities

The first segment of this form spells out very clearly what is expected of the member or their LAR when they take on the responsibilities of an employer.

If the member is worried about being able to fulfill all of these responsibilities, this is where the discussion about available support should be held.

There may be a family member or friend who can take on the responsibilities of a Designated Representative (DR) to help the member.

Remember the DR is a volunteer position that allows the member to have assistance with employer responsibilities.



The "**employer**" in the CDS option is the individual receiving services or, when applicable, the individual's legally authorized representative (LAR).

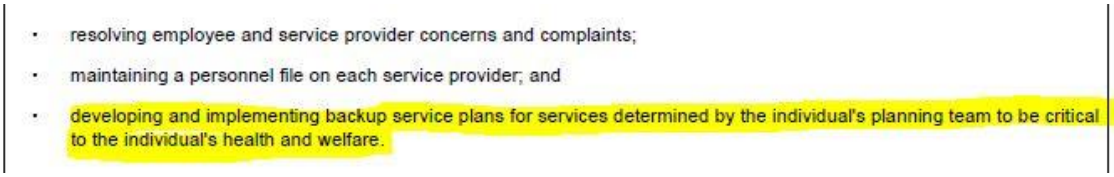
Employer Responsibilities

To participate in the CDS option, you must be able to perform all employer tasks required, or you may appoint a willing adult as your **designated representative** (DR) to assist you or to perform employer responsibilities and tasks for you.

As an employer, your responsibilities include:

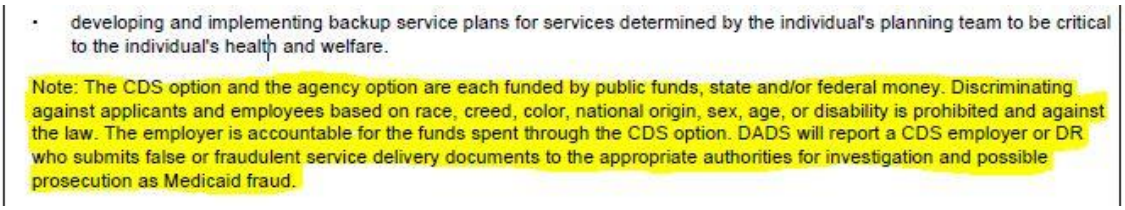
- recruiting, hiring, training, managing and firing your employees and other service providers (service providers include employees, contractors and vendors);

Service Backup Plan – An important responsibility that is reference on this form is the development and implementation of a Service Backup Plan for the services determined by the individual's planning team to be critical to the member's health and welfare. The Service Backup Plan is designated on Form 1740. This form is explained later in this document.



- resolving employee and service provider concerns and complaints;
- maintaining a personnel file on each service provider; and
- developing and implementing backup service plans for services determined by the individual's planning team to be critical to the individual's health and welfare.

Discrimination and Fraud – A key section of employer responsibilities deals with discrimination and Medicaid fraud. Employers must not discriminate. Additionally some employers think of these authorized services as "their money." This segment serves to remind them that it is not.



- developing and implementing backup service plans for services determined by the individual's planning team to be critical to the individual's health and welfare.

Note: The CDS option and the agency option are each funded by public funds, state and/or federal money. Discriminating against applicants and employees based on race, creed, color, national origin, sex, age, or disability is prohibited and against the law. The employer is accountable for the funds spent through the CDS option. DADS will report a CDS employer or DR who submits false or fraudulent service delivery documents to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

Note: The CDS option and the agency option are each funded by public funds, state and/or federal money. Discriminating against applicants and employees based on race,

creed, color, national origin, sex, age, or disability is prohibited and against the law. The employer is accountable for the funds spent through the CDS option. The FMSA will report a CDS employer or DR who submits false or fraudulent service delivery documents to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

Form 1582 – Page 1 – Service Coordinator Responsibilities

The bottom half of page one reminds the member/employer of your responsibilities as a Service Coordinator. It reinforces to your member that you are their primary contact when there are changes in their status or if they need additional assistance.

Case Manager and Service Coordinator Responsibilities

Your case manager or service coordinator is responsible for informing you about the CDS option and reviewing the self-assessment tool with you to help you determine if the CDS option is right for you. In addition, the responsibilities of your case manager or service coordinator include:

- assessing your service level needs;
- coordinating the development of the service plan or plan of care;
- presenting a list of available FMSA providers from which to select;
- educating you on your rights, responsibilities and resources;
- revising your service plan when your needs change;
- being a resource if you have health, safety or exploitation concerns; and
- monitoring and reviewing your satisfaction with the services provided by the FMSA in accordance with the requirements of your program.

Form 1582 – Page 2 – FMSA Responsibilities

The second page spells out the responsibilities of the FMSA. The FMSA will conduct a face-to-face orientation with the member. If the member is under 18 or has a guardian, the LAR or guardian must be present at orientation.

HERE IS SOME ADDITIONAL INFORMATION ON EACH OF THE RESPONSIBILITIES OF THE FMSA THAT MAY BE HELPFUL TO YOU IN REVIEWING THIS FORM WITH YOUR MEMBER.

Responsibilities of the Financial Management Services Agency

The employer must select a FMSA before the CDS option can be started. You can expect your FMSA to perform the following services for you:

- orient and train the employer/DR about employer responsibilities for the CDS option to include legal requirements of various governmental agencies;
- assist and approve budgets for each service to be delivered through CDS;

- ***orient and train the employer/DR about employer responsibilities for the CDS option to include legal requirements of various governmental agencies;***

This paragraph refers to the responsibilities of the FMSA to conduct a face to face orientation and explain fully the responsibilities the member/employer has when the CDS option is chosen. At orientation, all federal and state tax forms are reviewed and explained.

- ***assist and approve budgets for each service to be delivered through CDS;***

This means that the FMSA will take the number of authorized hours of service and show the employer the amount of money that is available to pay for those hours. The FMSA will then assist the employer in determining what employer supports may be needed (like a fax machine and funds for criminal history and registry checks). The FMSA will show the employer the maximum they are able to pay per hour and discuss other options, such as bonuses, or paid vacation. The employer makes the decision on pay structure – not the FMSA. The FMSA's role is to show the employer their options.

IMPORTANT: The authorized rate is not the rate of pay. Out of the authorized rate, the employer must cover employer supports (that fax machine), state and federal unemployment taxes, as well as the employer match for FICA and Medicare. The rate of pay is also affected by the number of authorized hours and the number of employees who are hired.

Example: For an employer using only one employee the FMSA will pay only one unemployment tax. If two employees are used, two unemployment taxes must be paid, reducing the funds available for the per hour rate.

- provide assistance in completing forms required to obtain an employer identification number (EIN) from federal and state agencies;
- conduct criminal history checks of applicants when requested by the employer or DR;
- verify each applicant's eligibility with program requirements, including Medicaid fraud exclusions, before an applicant is employed or retained by the employer;
- register as your employer-agent with the Internal Revenue Service (IRS) and assume full liability for filing reports and paying employer taxes on the CDS employer's behalf, to the IRS;

- ***provide assistance in completing forms required to obtain an employer identification number (EIN) from federal and state agencies;***
- ***register as your employer-agent with the Internal Revenue Service (IRS) and assume full liability for filing reports and paying employer taxes on the CDS employer's behalf, to the IRS;***

At orientation the FMSA will normally have the member/employer sign all of the state and federal forms that are needed by the FMSA to establish the member or the legally authorized representative (guardian) as the employer and to allow the FMSA to act as an agent for the employer. The FMSA will also educate the member/employer on the forms used to hire an employee

- provide assistance in completing forms required to obtain an employer identification number (EIN) from federal and state agencies;
- conduct criminal history checks of applicants when requested by the employer or DR;
- verify each applicant's eligibility with program requirements, including Medicaid fraud exclusions, before an applicant is employed or retained by the employer;
- register as your employer-agent with the Internal Revenue Service (IRS) and assume full liability for filing reports and paying employer taxes on the CDS employer's behalf, to the IRS;

- **conduct criminal history checks of applicants when requested by the employer or DR;**

- **verify each applicant's eligibility with program requirements, including Medicaid fraud exclusions, before an applicant is employed or retained by the employer;**

Once the orientation is complete, the member/employer should start the process of hiring an employee. It is important that the member remember that no employee can start working until **four criteria** have been met:

1) The member is Medicaid eligible;
2) Services have been authorized;
3) The start of care date on the authorization has been reached;
4) The FMSA has approved the employee to start work.

An important part of determining eligibility to work is conducting the criminal history checks, registry checks, Medicaid fraud exclusions and other program requirements. This is done by the FMSA.

- receive and process employee time sheets, compute and pay all federal and state employment-related taxes and withholdings, and distribute payroll at least twice a month;
- receive and process invoices and receipts for payment;
- maintain records of all expenses and reimbursement and monitor budget;
- provide written summaries and budget balances of payroll and other expenses at least quarterly;
- prepare and file employer-related tax and withholding forms and reports (this does not include filing personal income tax returns for you or your employees); and

- **receive and process employee time sheets, compute and pay all federal and state employment-related taxes and withholdings, and distribute payroll at least twice a month;**

- **prepare and file employer-related tax and withholding forms and reports (this does not include filing personal income tax returns for you or your employees);**

The employer is responsible for turning in timesheets and for making sure they are accurate. The FMSA is responsible for making sure the hours reported are within the member's service authorization; for adhering to state and federal regulations in processing payroll; for paying all taxes due; and for completing and filing all state and federal tax returns associated with the CDS services.

OTHER FMSA RESPONSIBILITIES LISTED INCLUDE:

- **receive and process invoices and receipts for payment;**
- **maintain records of all expenses and reimbursement and monitor budget;**
- **provide written summaries and budget balances of payroll and other expenses at least quarterly;**
- **provide ongoing training and assistance as needed or requested.**

Both you and the member/employer should receive quarterly reports which show hours and funds used for payroll, employer expenses, etc.

Form 1582 – Page 2 – Additional Employer Responsibilities

The last section of page two covers additional employer responsibilities. It is important that the member/employer understand that if they are not happy with the CDS option, they can return to the agency option at any time.

If they are not happy with their FMSA, and have not been able to resolve their issues with their FMSA, they should call you, the Service Coordinator, for assistance. *(See Appendix B for more information on how the member files a complaint against the FMSA.)*

Additional Employer Responsibilities

If you feel that your FMSA is not fulfilling responsibilities or meeting your needs, you must:

- address those issues directly with the FMSA;
- contact your case manager or service coordinator if you and the FMSA are not able to resolve your concerns and issues;
- select another FMSA to provide your CDS services if concerns and issues are still not resolved; and
- notify your case manager or service coordinator if you decide you want to transfer from one FMSA to another. Your case manager or service coordinator will make all the necessary arrangements for the transfer.

You may begin or end the CDS option at any time by contacting your case manager or service coordinator. If you end the CDS option, you must remain in the "agency" option for at least 90 days before returning to the CDS option.

You may change any provider agency at any time, including a FMSA or a program "agency" provider, by contacting your case manager or service coordinator.

Form 1582 – Page 3 – CDS Option Advantages vs. Potential Risks

Page three of this form lists the advantages and risks associated with the CDS option. Read through this carefully with the member.

Consumer Directed Services Responsibilities (Continued) Form 1582 Page 3 /11-2013-E

CDS Option Advantages vs. Potential Risks

Advantages in the CDS option

- You select and manage the people who provide your services.
- You schedule who provides program services and when they are delivered.
- You train your service providers and supervise the services delivered by your service providers (service providers include employees, contractors and vendors).
- You control the rate of pay for your employee(s) within the spending limits of the unit rate for the service.
- You can offer benefits, such as bonuses, vacation pay, sick pay and insurance, to your employees.
- You select an FMSA that will pay your service providers, make deposits and file reports with governmental agencies on your behalf.
- You may be able to recruit eligible service providers, including family members, friends and other persons you know to work for you. The person selected must meet all eligibility requirements of your program to be hired or retained.
- You may appoint someone to assist with employer responsibilities or to perform employer responsibilities for you.

NOTE: An important advantage that is <u>not</u> listed is that generally, the CDS employer is able to pay more per hour than the traditional home care agency.

Potential Risks in the CDS option

- You are responsible for backup arrangements for services to be delivered if your employee or service provider does not show up for work.
- Your service providers are **not** the employees of the FMSA, the Department of Aging and Disability Services (DADS), any other state or federal agency or any other contracted provider agency.
- As the employer, you are solely responsible and liable for any negligent acts or omissions by you, your employees, other service providers and your DR.
- You are responsible for handling all conflicts with service providers. The FMSA and the individual's other program provider agencies are not involved in these situations.
- You are required to keep and store paperwork for up to five years or possibly longer.
- The employer is ultimately responsible for payroll taxes owed to the Texas Workforce Commission (TWC), and is liable if the FMSA fails to pay. The FMSA assumes full responsibility for payment of payroll taxes owed to the IRS.
- The employer is responsible for meeting all requirements as any employer in any business and can be held liable for failure to meet those requirements.

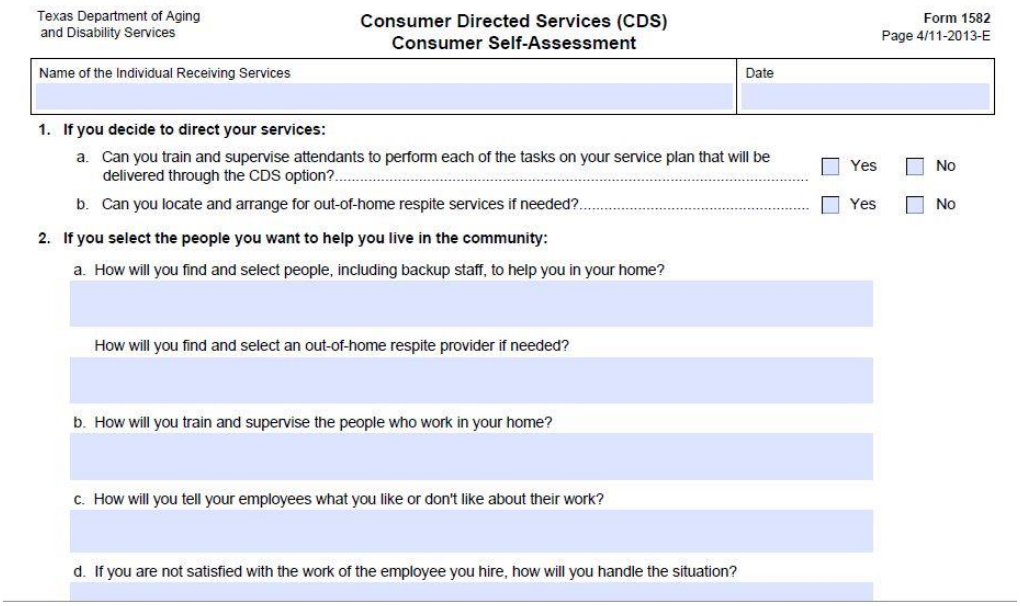
1) The first highlighted risk deals with the risk to the employer directly:
   - ***As the employer, you are solely responsible and liable for any negligent acts or omissions by you, your employees, other service providers and your DR.***
     - **Example: an employer may be liable for the cost of medical care for an employee injured on the job.**

2) The second highlighted risk that may cause concern to a member has to do with tax liability:
   - ***The employer is ultimately responsible for payroll taxes owed to the Texas Workforce Commission (TWC), and is liable if the FMSA fails to pay.***
     - **The employer may request proof from their FMSA that the TWC quarterly report has been filed and paid on time.**

Form 1582 – Page 4 – Consumer Self-Assessment

Page four contains an employer self-assessment designed to show you whether the member is ready to self-direct their services.

- If the member cannot complete this form on their own, it does not mean that they cannot use the CDS option. It does mean that they must utilize a Designated Representative (DR). This is important to the FMSA. If the member will be using a DR, the FMSA needs to know that at the time of referral, so that they can make sure the DR is present at orientation. If the member will need a DR, the DR should be identified before the referral is made to the FMS agency. The Service Coordinator should then include this information on the referral along with the contact information for the Designated Representative.



Texas Department of Aging and Disability Services

Consumer Directed Services (CDS)
Consumer Self-Assessment

Form 1582
Page 4/11-2013-E

Name of the Individual Receiving Services	Date

1. **If you decide to direct your services:**
   a. Can you train and supervise attendants to perform each of the tasks on your service plan that will be delivered through the CDS option? ☐ Yes ☐ No
   b. Can you locate and arrange for out-of-home respite services if needed? ☐ Yes ☐ No
2. **If you select the people you want to help you live in the community:**
   a. How will you find and select people, including backup staff, to help you in your home?

   How will you find and select an out-of-home respite provider if needed?

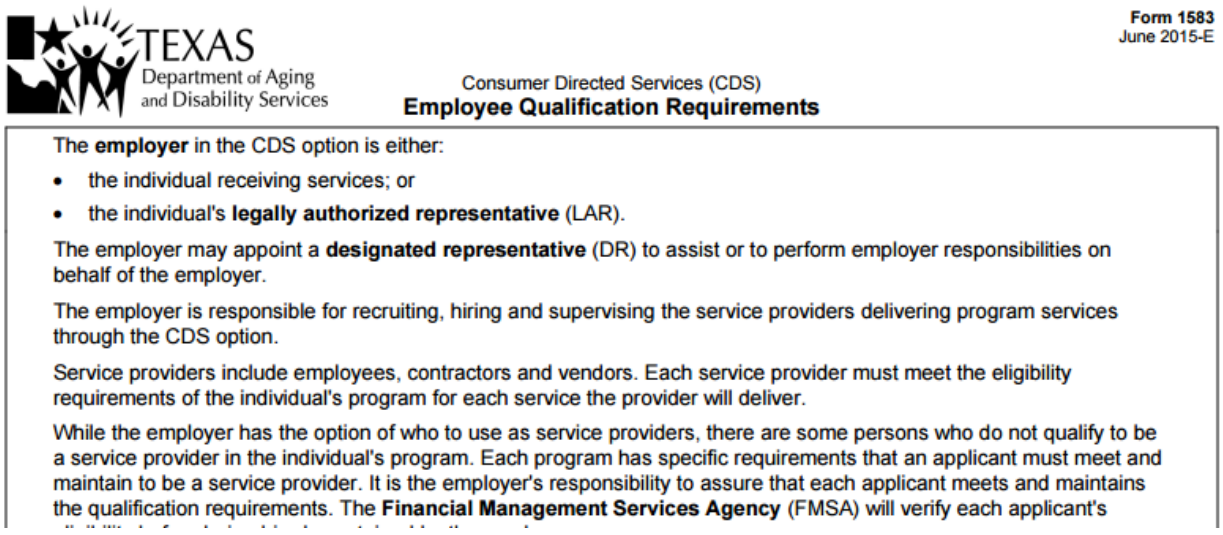
   b. How will you train and supervise the people who work in your home?

   c. How will you tell your employees what you like or don't like about their work?

   d. If you are not satisfied with the work of the employee you hire, how will you handle the situation?

Form 1583 – Employee Qualification Requirements

Purpose: To provide information to the Member/LAR of additional responsibilities of being an employer in the CDS option, including who may or may not be hired in CDS. To hire an ineligible employee could be considered Medicaid fraud.



TEXAS Department of Aging and Disability Services

Form 1583
June 2015-E

Consumer Directed Services (CDS)
Employee Qualification Requirements

The **employer** in the CDS option is either:

- the individual receiving services; or
- the individual's **legally authorized representative** (LAR).

The employer may appoint a **designated representative** (DR) to assist or to perform employer responsibilities on behalf of the employer.

The employer is responsible for recruiting, hiring and supervising the service providers delivering program services through the CDS option.

Service providers include employees, contractors and vendors. Each service provider must meet the eligibility requirements of the individual's program for each service the provider will deliver.

While the employer has the option of who to use as service providers, there are some persons who do not qualify to be a service provider in the individual's program. Each program has specific requirements that an applicant must meet and maintain to be a service provider. It is the employer's responsibility to assure that each applicant meets and maintains the qualification requirements. The **Financial Management Services Agency** (FMSA) will verify each applicant's

Form 1583 – Page 1 – Who Can Be the Employer?

The top of page one spells out who will be the employer. The Service Coordinator will need to help the member determine who this will be.

THE EMPLOYER IN THE CDS OPTION IS EITHER:

1) the individual receiving services.

OR

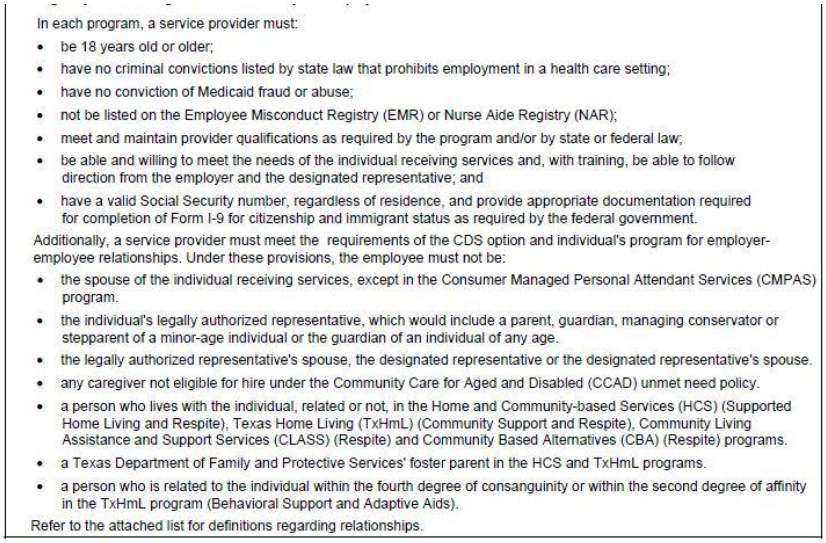
2) the individual's legally authorized representative (LAR).

- If the member is under 18, the parent, court appointed guardian, or LAR is the employer. If the member is over 18 and does not have a court appointed guardian, they will be the employer.

- If the member does not have the ability to manage CDS employer responsibilities *and does not have a court appointed guardian*, the member is the employer *AND* must have a Designated Representative (DR).

- If the member has a court appointed guardian, the guardian is the employer. **Form 1583 – Page 1 – Who Can Be the Employee?**

The rest of page one lists who can and cannot work and what qualifications a prospective employee must meet. It also lists those individuals who, because of their relationship to the member, the employer, the Designated Representative, or other Legally Authorized Representative may not work.



In each program, a service provider must:

- be 18 years old or older;
- have no criminal convictions listed by state law that prohibits employment in a health care setting;
- have no conviction of Medicaid fraud or abuse;
- not be listed on the Employee Misconduct Registry (EMR) or Nurse Aide Registry (NAR);
- meet and maintain provider qualifications as required by the program and/or by state or federal law;
- be able and willing to meet the needs of the individual receiving services and, with training, be able to follow direction from the employer and the designated representative; and
- have a valid Social Security number, regardless of residence, and provide appropriate documentation required for completion of Form I-9 for citizenship and immigrant status as required by the federal government.

Additionally, a service provider must meet the requirements of the CDS option and individual's program for employer-employee relationships. Under these provisions, the employee must not be:

- the spouse of the individual receiving services, except in the Consumer Managed Personal Attendant Services (CMPAS) program.
- the individual's legally authorized representative, which would include a parent, guardian, managing conservator or stepparent of a minor-age individual or the guardian of an individual of any age.
- the legally authorized representative's spouse, the designated representative or the designated representative's spouse.
- any caregiver not eligible for hire under the Community Care for Aged and Disabled (CCAD) unmet need policy.
- a person who lives with the individual, related or not, in the Home and Community-based Services (HCS) (Supported Home Living and Respite), Texas Home Living (TxHmL) (Community Support and Respite), Community Living Assistance and Support Services (CLASS) (Respite) and Community Based Alternatives (CBA) (Respite) programs.
- a Texas Department of Family and Protective Services' foster parent in the HCS and TxHmL programs.
- a person who is related to the individual within the fourth degree of consanguinity or within the second degree of affinity in the TxHmL program (Behavioral Support and Adaptive Aids).

Refer to the attached list for definitions regarding relationships.

Form 1583 – Page 2 – Relationship Definitions

Page two defines the relationships that are referenced on page one.

Employer and Employee
Relationship Determination

Definitions:

1. The **individual** is the *individual receiving services* who is either:
   - a **minor**, a person who is under age 18 (17 and younger); or
   - an **adult** who is a person age 18 or older.
2. An **employer** is defined as:
   - an individual who is an **adult** with no legally appointed guardian;
   - a parent or guardian of an individual who is a **minor;**
   - a natural parent, legal/adopted parent, stepparent and/or a court-appointed guardian is the **legally authorized representative** (LAR) of the individual;
   - a foster parent who must also have written authorization from the Department of Family and Protective Services (DFPS) to be the employer; or
   - the legally appointed guardian of an individual of any age is the **legally authorized representative** (LAR) for the individual.
3. A **designated representative (DR)** is:

Form 1584 – Consumer Participation Choice

Purpose: Form 1584 is where the member chooses to participate in the CDS option or declines CDS and selects the agency option.

After you have reviewed forms 1581, 1582 and 1583 with your member, and they have chosen the CDS option. The next step is to select an FMSA. At this point, you provide the member with a list of CDS agencies. (Remember, the agency does not have to be physically located in the city where the member lives.) See the next section for information on how to choose an FMSA.

TEXAS Department of Aging and Disability Services

Form 1584
June 2015-E

Consumer Participation Choice

Individual's Name	Individual's No.

My case manager/service coordinator has presented adequate information for me to make an informed choice between services through the Agency Option (AO), the Consumer Directed Services (CDS) option or the Service Responsibility Option (SRO). I understand my rights and responsibilities in each option. My signature below documents my choice of how I want my services to be delivered. I understand I can contact my case manager/ service coordinator if I wish to change my selection at a later date.

Options Available

☐ **Agency Option**

I elect to have *all* of my direct services delivered by the provider.

_____

Name of Provider

☐ **CDS Option**

I elect to receive my services available through the CDS option.

I have selected _____ as my Financial Management Services Agency (FMSA).

Name of Provider

☐ **Service Responsibility Option (only if available in your program)**

I elect to receive my services available through the SRO. This option is only available for individuals receiving services through Primary Home Care, Family Care or Community Attendant Services.

I have selected _____ as my SRO provider.

Name of Provider

Form 1585 – Acknowledgment for Exemption from Nursing Licensure for Certain Services Delivered through CDS

Purpose: To record the employer's agreement to assume the responsibility for the training, directing and supervising of employees to provide some nursing tasks

In reviewing the Service Plan, the Service Coordinator **must** be able to identify whether there are any services which can be performed without a nursing license or nursing delegation. These services are spelled out in the Form 1585.

Those services which may be provided by an attendant without nursing delegation are classified as health maintenance activities. While the Form 1585 lists those tasks which can be done without nursing delegation, the Service Coordinator must be confident of the health status of the member, and the ability of the member or member's family to train the attendant in the required service.

If any of the services your member will need fall into this category, you must review this form with the member before making the referral for CDS services. If you are not an RN, you should reach out to an RN for assistance in determining whether it is appropriate for any of the tasks on the member's service plan to be exempt from nursing delegation.

The first part of the form explains the employer's responsibilities and outlines the qualifications necessary for an unlicensed individual to perform the exempt tasks

Texas Department of Aging
and Disability Services

Form 1585
October 2013-E

Acknowledgement of Responsibility for Exemption from
Nursing Licensure for Certain Services Delivered through Consumer Directed Services (CDS)

The following text is from Section 531.051, Government Code, Consumer Direction of Certain Services for Persons with Disabilities and Elderly Persons, Subsections (e) and (f):

The consumer in the CDS option acknowledges that, as "the consumer who receives the service," he or she (e)(2)(A) "has a functional disability and the service would have been performed by the consumer, or the parent or guardian for the consumer, except for that disability; and if:

(e)(2)(B)(i) the consumer is capable of training the person in the proper performance of the service, the consumer directs the person to deliver the service; or

(e)(2)(B)(ii) the consumer is not capable of training the person in the proper performance of the service, the consumer's parent or guardian is capable of training the person in the proper performance of the service and directs the person to deliver the service.

(f) If the person delivers the service under Subsection (e)(2)(B)(ii), the parent or guardian must be present when the service is performed or immediately accessible to the person who delivers the service. If the person will perform the service when the parent or guardian is not present, the parent or guardian must observe the person performing the service at least once to assure the parent or guardian that the person performing the service can competently perform that service.

The person who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter 301, Occupations Code, that is revoked or suspended; and

(C) performs a service that is **not expressly prohibited from delegation by the Texas Board of Nursing.**

Per Texas Administrative Code, §225.12,**Tasks Prohibited From Delegation, the following are nursing tasks**

The next section details those tasks expressly prohibited from delegation:

Per Texas Administrative Code, §225.12,**Tasks Prohibited From Delegation, the following are nursing tasks that cannot be delegated:**

(1) physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;

(2) formulation of the nursing care plan and evaluation of the client's response to the care rendered;

(3) specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;

(4) the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and

(5) the following tasks related to medication administration:

(A) calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;

(B) administration of medications by an injectable route except for subcutaneous injectable insulin as permitted by §225.11(b) of this title (relating to Delegation of Administration of Medications From Pill Reminder Container and Administration of Insulin);

(C) administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) of this title (relating to Task That May Be Delegated);

(D) responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and

(E) administration of the initial dose of a medication that has not been previously administered to the client.

The third section lists examples of those tasks which can be performed by an unlicensed employee:

Under §531.052(e), (f) of the Government Code, there are certain services that may be exempt from nursing licensure and can be included in the Individual Service Plan for the CDS option if all the qualifying conditions are met.

Examples include:

(1) bathing, including feminine hygiene;

(2) grooming, including nail care, except for consumers with medical conditions like diabetes;

(3) feeding, including feeding through a permanently placed feeding tube;

(4) routine skin care, including decubitus Stage 1;

(5) transferring, ambulation or positioning;

(6) exercising and range of motion;

(7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;

(8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube; and

(9) non-invasive and non-sterile treatments with low risk of infection.

And the last section contains the acknowledgement and agreement of the employer and/or the LAR that they are willing and capable of taking the responsibility for training and supervision of any employee.

CDS Consumer

I **elect** to take responsibility for some nursing tasks. I have read the excerpt provided from Government Code §531.051 and under those terms, **I certify the following:**

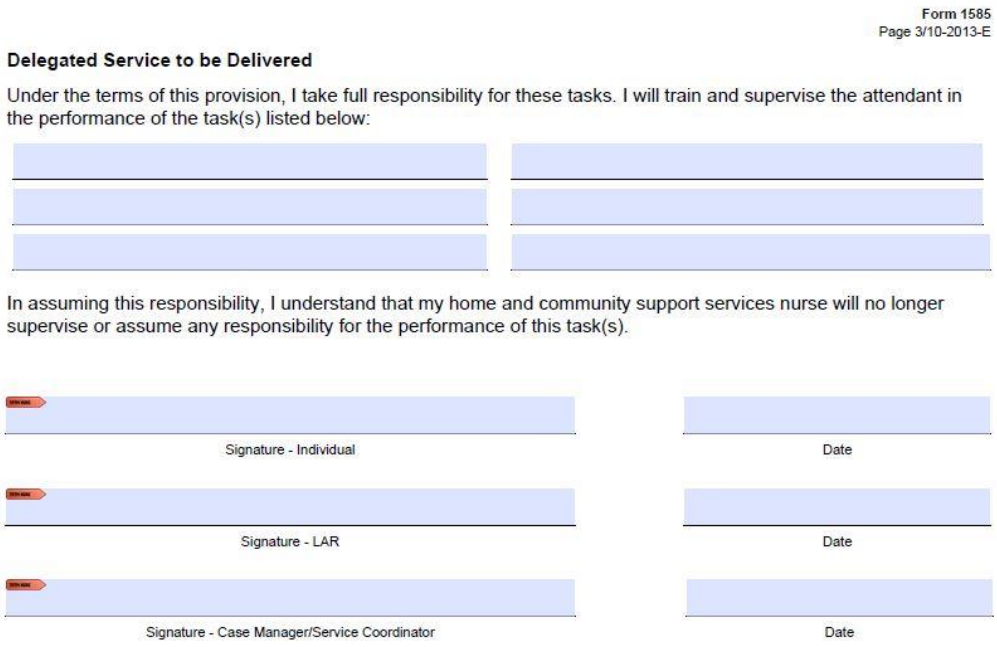
As the individual who receives the service, I certify that I have a functional disability and I am able to perform this service for myself, except for that disability.

As the individual of the service, I am capable of training the attendant (employee) in the proper performance of the service and take full responsibility in directing and supervising the attendant. I understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.12, **Tasks Prohibited From Delegation,** must not be provided by the employee.

Legally Authorized Representative (LAR) Directed Services

I **elect** to take responsibility for some nursing tasks for the individual. I have read the excerpt provided from Government Code §531.051 and under those terms, **I certify the following:**

As the LAR of the individual, I am capable of training the attendant (employee) in the proper performance of the service and take full responsibility in directing and supervising the attendant. I will either be present or immediately accessible when the service is performed or will observe the attendant performing the service until I am assured he is able to competently perform the service without my immediate supervision. I understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.12, **Tasks Prohibited From Delegation,** must not be provided by the employee.



Form 1585
Page 3/10-2013-E

Delegated Service to be Delivered

Under the terms of this provision, I take full responsibility for these tasks. I will train and supervise the attendant in the performance of the task(s) listed below:

In assuming this responsibility, I understand that my home and community support services nurse will no longer supervise or assume any responsibility for the performance of this task(s).

Signature - Individual

Date

Signature - LAR

Date

Signature - Case Manager/Service Coordinator

Date

If this form is completed, a copy of it should be provided to the FMSA when the referral for CDS services is made.

Form 1586 – Support Consultation

Purpose: To educate the employer on the availability of support consultation to employers who feel they need extra support in recruiting, training, or managing their employees or with other elements of being an employer.

Support Consultation Services must not duplicate or replace services to be delivered through a Service Coordinator, the Financial Management Services Agency (FMSA) or other sources. A support advisor is a job coach who provides skills-specific training, assistance and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.

Texas Department of Aging and Disability Services

Form 1586
December 2013-E

Acknowledgement of Information Regarding Support Consultation Services in the Consumer Directed Services (CDS) Option

Support Consultation Services

Support Consultation Services are only available to individuals participating in certain programs offering the CDS option. It is an optional service. An individual's service planning team may recommend that an individual access the service when the employer (the individual or legally authorized representative (LAR)) or the designated representative (DR) would benefit from additional support with employer responsibilities.

Support Consultation Services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the Financial Management Services Agency (FMSA) or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.

Support Advisor

Support Consultation Services are delivered by a support advisor. A support advisor must be certified by the Texas Department of Aging and Disability Services (DADS).

A support advisor must meet the eligibility requirements and provide services in accordance with Subchapter F, Support Consultation Services and Support Advisor Responsibilities, of the Texas Administrative Code (TAC), Title 40, Part 1, Chapter 41, Consumer Directed Services Option.

Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility; assistance with developing job descriptions; coaching on problem solving and coordinating employee management activities; training on developing and implementing service backup and corrective action plans; and coaching on handling other employer responsibilities.

Every FMSA is required to have a support advisor on staff or under contract. The support advisor does not take on any of the responsibilities of the employer. Typically, if needed, 5 to 10 hours of support consultation will be allocated per year. These funds are to be budgeted out of the total unit amount available to the member. The allocation of funds for a support advisor should not increase the total authorized Service Plan.

The member does not have to use the support advisor under contract or on the staff of the FMSA. The member may choose their own support advisor from the list available on the DADS' CDS website: http://www.dads.state.tx.us/providers/cds/advisors.cfm.
The support advisor will be an employee of the member and will have to fill out all employee paperwork. They do not have to be under contract with the MCO. They will be paid by the FMSA.

Selecting a Financial Management Services Agency

The Service Coordinator provides the member with a list of FMSAs. But, how does the member choose which one to use? The best method is to call and interview several agencies.

Questions the member may use to interview the FMSAs:

- How long have you been in business?

- What exactly will you do for me?
- How often do you pay? Do you offer direct deposit?
- If I move to another program or another city, can you continue to support me on CDS?
- How many people in CDS does your company currently serve?
- How many people within your company are familiar with CDS and when did those individuals last attend a FMSA training presented by DADS?
- Have you had any complaints about handling payroll taxes and employer related taxes?
- Have you been monitored by the State?
- How long does it take you to process a new employee?
- How would you say your agency is different from other FMSAs?
- Do you have a website?
- Can you give me 2-3 names of people I can contact as references?
- Have you ever paid penalties for late payment of payroll?

Getting Started On CDS

Initial Steps

Once your member has decided on the CDS option and selected an FMA, you will make the referral. This is the information that you need to send to the FMSA when the initial referral is made:

1) Member's name, date of birth, Medicaid number, and contact information; if the member has a family member or friend who speaks for them that contact name and number is needed.
2) If the member has a guardian or someone holding a power of attorney, the FMSA needs that information.
3) When services should start. (or an estimate, or notation that member is currently receiving services from a home care agency or another FMSA)
4) The type of service and number of hours that will be authorized. (or an estimate)
5) Copies of the Forms 1582, 1584, and 1740 (service back up plan)

When a referral is made, these are generally the steps taken by the FMSA:

1) An initial phone contact to answer the member's questions; obtain some basic information; and arrange to schedule the orientation.

2) A face to face orientation to give the member an overview of what is required in the CDS option and to obtain the materials necessary to set them up as employers.

3) Provide the materials they need to learn more about CDS, including the CDS employer's manual from DADS.

   NOTE: Members are given the DADS Employer Handbook which covers many aspects of being an employer.

After Orientation

After orientation the FMSA should notify you that orientation is complete. Then, the following tasks must be completed:

1) You and the FMSA will decide on a start date if one has not already been set.

2) The FMSA will work with the member in preparing a budget so they know how much they can pay their employees.

3) The FMSA will assist the member in qualifying their employees to work, including doing the criminal history check and other registry checks.

Setting a Date for CDS Services to Start

When to start CDS services? This is less important when a member is not currently receiving LTS services. If they are using the agency option and are receiving attendant or nursing services, the Service Coordinator **should not set a start date until the member has completed orientation and the individuals they intend to use as employees have been cleared to work.**

Employers are told that they may not allow someone to start working until the FMSA has cleared them to work. Members frequently overlook this and do not send in the forms that are needed to clear an employee to work right away.

If a member allows an employee to work before clearance is given, the FMSA cannot pay for those hours, and the employer is responsible for those wages.

Sending the Service Authorization to the FMSA

The services listed below can be provided under the CDS option.
When issuing the authorization for CDS services, it is important that the appropriate codes are listed. Please refer to the appropriate codes when you make you referral. You will notice that the primary difference from a home care agency referral is in the modifiers. It is very important that the modifiers be correct. It is time-consuming for Service Coordinators to have to correct authorizations issued with incorrect HCPC codes or modifiers.

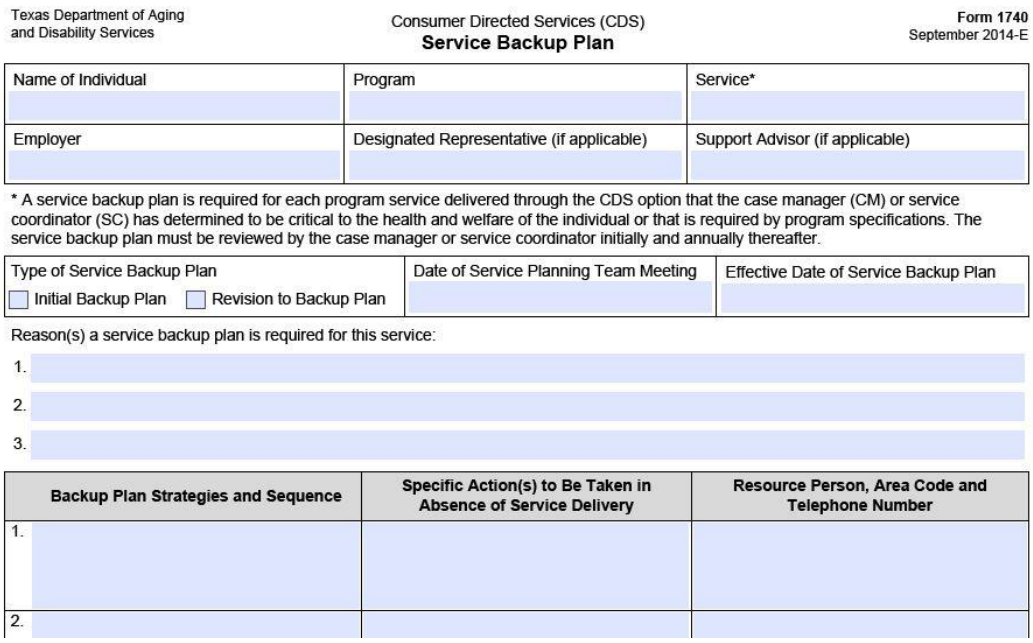
Service	STAR Kids	STAR Kids MDCP	HCPCS Code	Modifiers			
				Mod 1	Mod 2	Mod 3	Mod 4
PCS	X		T1019	UC			
CFC Personal Assistance	X		T1019	U3			
CFC Habilitation & Personal Assistance	X		T1019	U4			
MDCP Respite- Attendant		X	H2015	U1	UC		
MDCP Respite- Attendant w/ nurse oversight		X	H2015	U1	UA	UC	
MDCP Respite- LVN		X	H2015	U3	UC		
MDCP Respite- Specialized LVN		X	H2015	U3	UA	UC	
MDCP Respite- RN		X	H2015	U5	UC		
MDCP Respite- Specialized RN		X	H2015	U5	UA	UC	
MDCP FFSS- Attendant		X	H2015	99	U1	UC	
MDCP FFSS- Attendant w/ nurse oversight		X	H2015	99	U1	UA	UC
MDCP FFSS- LVN		X	H2015	99	U3	UC	
MDCP FFSS- Specialized LVN		X	H2015	99	U3	UA	UC
MDCP FFSS- RN		X	H2015	99	U5	UC	
MDCP FFSS- Specialized RN		X	H2015	99	U5	UA	UC
MDCP- Supported Employment		X	H2023	UC			
MDCP- Employment Assistance		X	H2025	UC			
FMSA Service Fee- PCS only	X		T2040	U8			
FMSA Service Fee- CFC	X		T2040	U5			
FMSA Service Fee- MDCP only		X	T2040	U3			
FMSA Service Fee- MDCP and CFC		X	T2040	U4			

What to Expect from the FMSA

- The FMSA is expected to keep track of hours and funds spent and send both members (the employers) and Service Coordinators quarterly reports that show how many hours have been used for what services, and how much money has been spent.
- The FMSA should show how funds have been allocated; i.e. funds for employer supports, employee benefits, overtime allocations, bonuses, taxes paid, etc.
- The FMSA should notify the employer and the Service Coordinator of any problems, such as not hiring an employee, or not following rules.
- The FMSA should be a resource to members. For example: assisting them in identifying potential employee recruitment techniques; helping them develop a weekly schedule; helping them in counseling employees.

Form 1740 – Service Backup Plan

In the service planning process, the Service Coordinator, the member, and any other participants of the Service Planning Team will determine what services are critical to the member's health and welfare. Those services will need a backup plan in case of emergency. This plan is designated on Form 1740.



Texas Department of Aging and Disability Services

Consumer Directed Services (CDS)
Service Backup Plan

Form 1740
September 2014-E

Name of Individual	Program	Service*
Employer	**Designated Representative (if applicable)**	**Support Advisor (if applicable)**

* A service backup plan is required for each program service delivered through the CDS option that the case manager (CM) or service coordinator (SC) has determined to be critical to the health and welfare of the individual or that is required by program specifications. The service backup plan must be reviewed by the case manager or service coordinator initially and annually thereafter.

Type of Service Backup Plan	Date of Service Planning Team Meeting	Effective Date of Service Backup Plan
☐ Initial Backup Plan ☐ Revision to Backup Plan		

Reason(s) a service backup plan is required for this service:

1.
2.
3.

Backup Plan Strategies and Sequence	Specific Action(s) to Be Taken in Absence of Service Delivery	Resource Person, Area Code and Telephone Number
1.		
2.		

- The service backup plan must list the steps the member, LAR or DR implements in the absence of the service provider. If not completed at the annual meeting, the member, LAR or DR should complete within 7 days and return to the Service Coordinator.

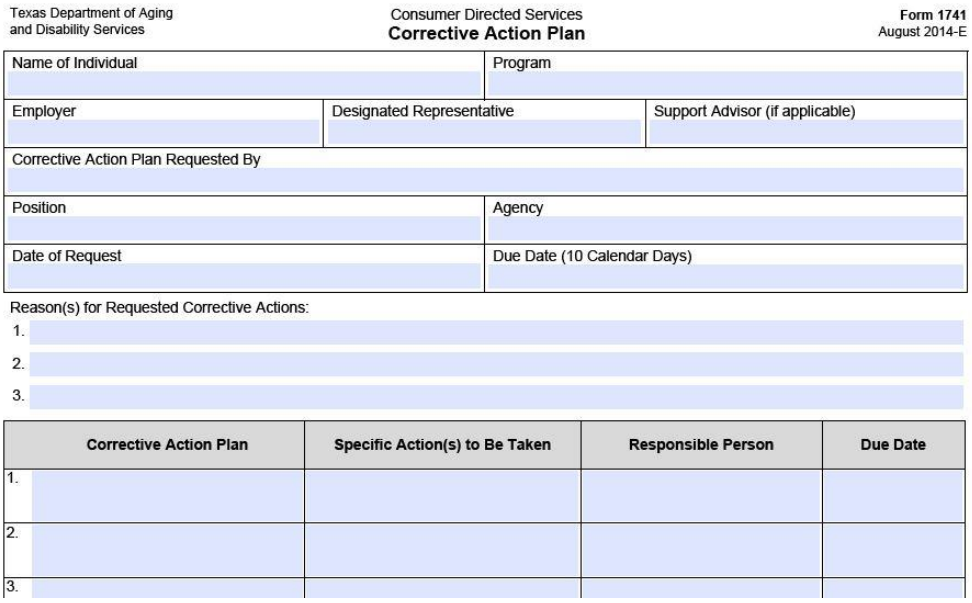
- The service backup plan may include the use of paid service providers, unpaid service providers such as family members, friends or non-program services, or respite (if included in the authorized service plan).

- The member, LAR or DR completes a backup plan to assure that all authorized services are delivered without a service break.

- The Service Backup Plan should be reviewed annually and if there are no changes, both the member and the Service Coordinator should initial and date it.
- The Service Backup Plan should also be reviewed any time there is a change in the member's status that would require revision, or any time a revision to the service backup plan is needed based on problems with implementation of the plan or changes in the resources required to carry out the plan.
- The Backup Plan must be approved by the member and the Service Coordinator. Both should keep a copy and a copy should go to the FMSA. **The Service Backup Plan should be in place before initiation of services in CDS.**

Form 1741 - Corrective Action Plan

If the member is not following program or CDS rules, the FMSA should bring these problems to the attention of the employer and assist them in correcting the deficiencies. If problems continue, the FMSA should use the Corrective Action Plan (CAP) to draw the member's attention to rules that must be followed, and the FMSA should involve you, the Service Coordinator, in this process.



Texas Department of Aging and Disability Services

Consumer Directed Services
Corrective Action Plan

Form 1741
August 2014-E

Name of Individual		Program
Employer	Designated Representative	Support Advisor (if applicable)
Corrective Action Plan Requested By		
Position		Agency
Date of Request		Due Date (10 Calendar Days)

Reason(s) for Requested Corrective Actions:

1.
2.
3.

	Corrective Action Plan	Specific Action(s) to Be Taken	Responsible Person	Due Date
1.				
2.				
3.				

A Corrective Action Plan:

1) describes the problem;
2) lists the actions that must be taken to solve the problem;
3) describes who is responsible for the actions to be taken and a timeframe to correct the problem.

A sample CAP which was successful is in Appendix A. The FMSA should send a copy of the CAP to the Service Coordinator when first developed and a copy of the completed CAP so that the Service Coordinator knows the outcome.

If the member/employer does not respond to the CAP, the FMSA should call the Service Coordinator to discuss the next action, which might be a 3-way telephone conference, or the Service Coordinator may wish to speak privately to the member, or to other involved family members.

The goal is to bring the employer into compliance. However, if the employer will not follow CDS rules, they may need to be returned to the agency option.

Electronic Visit Verification - EVV

At the present time a member's participation in Electronic Visit Verification in the CDS service delivery option is voluntary.

The FMSA will educate the member on EVV and offer it as an option.

Transfer Process

From time to time an employer may wish to transfer from one FMSA to another or from an FMSA back to the agency option.

When this happens the Service Coordinator should notify the FMSA. The FMSA must then:

1) Determine the funds/hours needed to cover payroll costs to the date of transfer.
2) Advise the SC of the number of hours left in the service plan.
3) Pay all taxes due and file all tax reports that are due.
4) If transferring to another FMSA, provide the receiving FMSA with tax identification numbers and tax deposit information.
5) Send a closing quarterly report to the member and the SC.
6) Send a discharge satisfaction survey to the member.
7) Close out TWC and IRS representation.

Complaints Process

Occasionally, an employer becomes dissatisfied with their FMSA. If the problem is recurring, the member should first try to resolve the issue with the FMSA. If no resolution can be reached, the employer should call their Service Coordinator and file a complaint. Then, the Service Coordinator and the employer will decide whether to attempt further resolution with the FMSA or whether to transfer to another FMSA.

In addition to filing a complaint with the Service Coordinator, the employer may also file a complaint against the FMSA by:

Calling the Complaint line: 1-800-252-8263 (Toll-Free)

Or write: HHSC Medicaid/CHIP
Health Plan Management
Mail Code H-320
P.O. Box 85200
4900 N. Lamar Blvd.
Austin, Texas 78708-5200

Or email: HPM_Complaints@HHSC.state.tx.us.

FMSA Record Keeping and Self-Reporting

FMSAs should keep a log of complaints, documenting date, time, narrative of the complaint, who conducted the investigation, steps of the investigation, and resolution. The member should sign a copy of the complaint form. Copies of the complaint should be forwarded to the MCO Service Coordinator, the member and a copy placed in the Complaint Log.

Appendix A

Forms

This appendix will contain the forms once they are available.

Appendix VIII Resource Utilization Groups

Resource Utilization Groups (RUG) Individual Plan of Care (IPC) Cost Limits

September 2015

Handbooks sharing this appendix

RUG IPC Cost Limits

RUG	Criteria	IPC Cost Limit
SE3	Extensive Services 3 / ADL > 6	$42,174
SE2	Extensive Services 2 / ADL > 6	$35,985
SE1	Extensive Services 1 / ADL > 6	$31,403
RAD	Rehabilitation All Levels / ADL 17-18	$35,505
RAC	Rehabilitation All Levels / ADL 14-16	$31,500
RAB	Rehabilitation All Levels / ADL 10-13	$29,656
RAA	Rehabilitation All Levels / ADL 4-9	$26,223
SSC	Special Care / ADL 17-18	$30,697
SSB	Special Care / ADL 15-16	$29,085
SSA	Special Care / ADL 4-14	$29,023
CC2	Clinically Complex with Depression / ADL 17-18	$25,291
CC1	Clinically Complex / ADL 17-18	$24,019
CB2	Clinically Complex with Depression / ADL 12-16	$23,298
CB1	Clinically Complex / ADL 12-16	$22,300
CA2	Clinically Complex with Depression / ADL 4-11	$21,230
CA1	Clinically Complex / ADL 4-11	$20,029
IB2	Cog. Impairment with Nursing Rehab / ADL 6-10	$21,261
IB1	Cog. Impairment / ADL 6-10	$19,902
IA2	Cog. Impairment with Nursing Rehab / ADL 4-5	$18,277
IA1	Cog. Impairment / ADL 4-5	$17,396
BB2	Behavior Problem with Nursing Rehab / ADL 6-10	$20,898
BB1	Behavior Problem / ADL 6-10	$19,026
BA2	Behavior Problem with Nursing Rehab / ADL 4-5	$17,956
BA1	Behavior Problem / ADL 4-5	$16,361
PE2	Physical Function with Nursing Rehab / ADL 16-18	$22,413
PE1	Physical Function / ADL 16-18	$21,254
PD2	Physical Function with Nursing Rehab / ADL 11-15	$21,537
PD1	Physical Function / ADL 11-15	$20,336
PC2	Physical Function with Nursing Rehab / ADL 9-10	$19,829
PC1	Physical Function / ADL 9-10	$19,062
PB2	Physical Function with Nursing Rehab / ADL 6-8	$18,589

RUG	Criteria	IPC Cost Limit
PB1	Physical Function / ADL 6-8	$17,746
PA2	Physical Function with Nursing Rehab / ADL 4-5	$16,715
PA1	Physical Function / ADL 4-5	$15,837

Appendix IX TxMedCentral Naming Convention

Form H2604, Individual Service Plan (ISP) Tracking Tool

This form is posted to the STAR Kids ISP folder and should be posted to all folders.

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	2604	123456789	ABCD		MFP

This file would be named ##_2604_123456789_ABCD_2.doc.

Form H3676, Managed Care Pre-Enrollment Assessment Authorization

This form is posted to the STAR Kids folder and should **not** be posted in any other folder.

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	3676	123456789	ABCD	A	2

This file would be named ##_3676_123456789_ABCD_A_2.doc.

Form H2065-D, Notification of Managed Care Program Services

This form is posted to the SKW folder and should **not** be posted in any other folder.

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	2065	123456789	ABCD	D	2D or 2A

- Denials will be coded with a “D” (denial) immediately following the form’s sequence number. This denial file would be named ##_2065_123456789_ABCD_D_2D.doc.
- Approvals will be coded with an “A” immediately following the sequence number. This approval file would be named ##_2065_123456789_ABCD_D_2A.doc.

Form H2067-MC, Managed Care Programs Communication

This form is posted to the STAR Kids folder and should **not** be posted in any other folder. An "M" or "S" is added to the sequence number to indicate whether the MCO or Program Support Unit (PSU) posted the form.

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	2067	123456789	ABCD	2M	

This file would be named ##_2067_123456789_ABCD_2M.doc.

Additional to the standardized naming convention for Form H2067-MC, Managed Care Programs Communication, a separate naming convention has been developed to address use of Form H2067-MC for nursing facility residents who request transition to the community under MDCP. These individuals are considered expedited cases for application to MDCP services. For this reason, staff from both the MCO and Program Support Unit (PSU) must be able to readily identify communications specific to these cases.

An "M" or "S" continues to be added to the sequence number to denote, respectively, whether the MCO or PSU has posted the form. The new naming convention for posting Form H2067-MC, on both member and non-member cases in a nursing facility, is expanded as follows:

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	2067	123456789	ABCD	1M or 1S	MFP

This form file posted by the MCO would be named ##_2067_123456789_ABCD_1M_MFP.doc.

TxMedCentral Folders

The STAR Kids MCOs use the following folders for all MDCP SKW related postings. Each MCO has two folders with three-letter identifiers:

- ISP — Individual Service Plan, which contains Form H2603 and Form H2604; and
- SKW — STAR Kids Waiver, which contains:
    - Form H2065-D, Notification of Managed Care Program Services;
    - Form H3676, Managed Care Pre-Enrollment Assessment Authorization; and